RN

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please send reprints of the following articles:

- ☐ 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957.
- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

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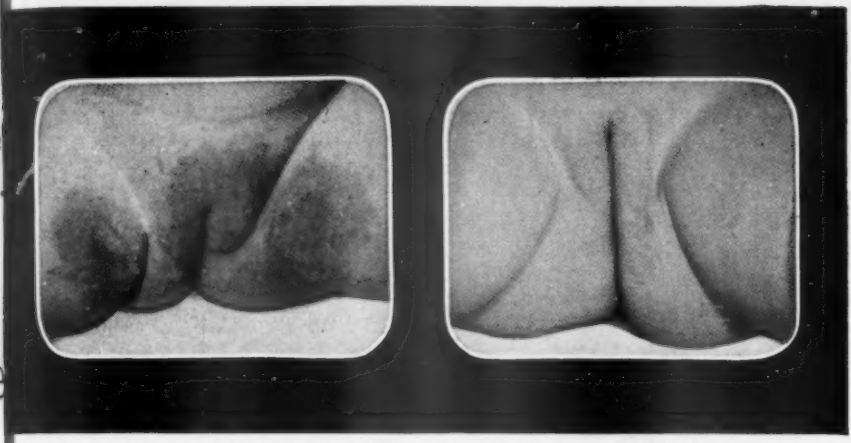

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RN letters

RX FOR THE SHORTAGE

DEAR EDITOR: "There's no single, simple remedy for the nurse shortage," said an M.D. committee in a recent news story.

True. But a great deal has been done here in California to solve the teacher shortage simply by giving teachers more recognition and better pay.

Professional recognition and good pay are important in America. Today's young women won't go into nursing when they can better themselves financially and professionally in so many other fields that weren't available to women twenty years ago.

The nurse shortage would be greatly relieved if R.N.s were recognized as true professionals—and paid accordingly.

Bernice Rosenberg, R.N.
Los Angeles, Calif.

SCHOOL PHYSICALS

DEAR EDITOR: Last year a routine school physical of my 11-year-old son showed that he had a coarctation of the aorta, a condition that otherwise might not have been discovered until irreversible damage had occurred.

Now surgery has corrected this condition. My son can look forward to a normal life.

This is why I don't agree with the Rochester (N.Y.) doctor who, as reported in *RN*, says that school health programs overemphasize physicals by M.D.s. Thank God our local schools *do* "overemphasize" them!

Bernell O'Donnell, R.N.
Corvallis, Ore.

HELPING THE HELPLESS

DEAR EDITOR: I've found the following ideas useful in caring for paralytics and aged invalids:

¶ To make it easy for a man to get his arms into his shirt sleeves: Split several sport shirts down the back, then hem and tape the split edges so they'll tie together like a hospital gown.

¶ To simplify his summertime dressing problem: Remove all pockets from his washable cotton trousers. Make some of the trousers into cool and serviceable Bermuda shorts by cutting them to knee length.

¶ To keep a bedfast invalid's bed as cool as possible: Spread a yard-wide strip of terry cloth

letters

across the width of the bed between the regular draw sheet and its plastic undersheet. Sew a strip of old sheeting onto each end of the terry cloth for a tuck-in.

Mary A. Brady, R.N.
Pomona, Calif.

SCHOOL PIN'S PLACE

DEAR EDITOR: I agree that a nurse's school pin should be worn over the heart *only*.

I'm not an R.N. yet (my mother is); but when I become one, I shall wear my pin proudly over my heart.

Marilyn Genung
Canisteo, N.Y.

DEAR EDITOR: . . . I've heard of a patient being injured by a pin worn over the heart. This pin, a sharp-pointed Maltese cross, accidentally caught on the sutures of a hare-lipped baby the nurse was holding.

Dorothy Oldham, R.N.
Valparaiso, Ind.

BIG MOUTH, BIG DAMAGE

DEAR EDITOR: Public criticism of the health professions is increasing, and part of the blame can be pinned on nurses like Mary S.

Mary is a good worker, but she talks too much. Throughout the 3-11 shift, she spreads the word that nursing is going to the dogs (except, of course, for her).

As she makes her 4 P.M. rounds, she lets Patients X, Y, and Z know how "shocked" she is to find that

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letters

the day nurse neglected to put ice in their water pitchers.

As she changes an abdominal dressing, she berates the day nurse for having left "such a mess"—despite the fact that profuse drainage, not the nurse's neglect is responsible.

As she makes her 10 P.M. rounds, she belittles the night nurse. The latter, she hints darkly, is not only neglectful but likely to sleep on the job.

Thus does Mary spread patient-discontent.

Even outside the hospital she does her damage. While at Kaffeeklatsches with "the girls" in her neighborhood, she freely criticizes M.D.s and R.N.s alike.

"I wouldn't let Dr. Blank touch my dog," she observes. Or she cites some harrowing experience that one of her patients allegedly went through because Nurse A (or Nurse B) didn't do her job.

Worse still, since Mary's cronies consider her an authority, they spread her insidious gossip all over town.

What can be done to muzzle these big mouths?

Virginia Mello, R.N.
Ashtabula, Ohio

SITTERS' REGISTRY

DEAR EDITOR: If more hospitals would keep a list of reliable baby sitters for married R.N.s to draw from, I'm sure more inactive R.N.s

letters

would work part time, at least. The auxiliary can maintain such a list as a part of its service to the hospital.

Betty R. Jackson, R.N.
Craig, Colo.

HYPNOSIS

DEAR EDITOR: The article by Diane Seide on "Hypnosis: Its Use in Medicine Today" [April, 1960 *RN*, prepared with the help of Milton V. Kline, PH.D., William Sweeney, M.D., and Albert M. Betcher, M.D.] is carefully written and logically reasoned. A psychologist, an obstetrician, and an anesthesiologist functioned as consultants for it. However, its subject matter must be considered as either psychiatric or as having psychiatric implications. As a result, the psychiatric background also needed for an article of this type was not obtained. For this reason, some essentially controversial material is stated as factual and some facts are omitted that I feel certain you would wish called to your readers' attention.

1. Hypnosis may or *may not* resemble sleep. Patients can be hypnotized even when voluntarily refusing to act as subjects and while not consciously aware that they are being hypnotized. It is incorrect to state that, to quote, "Patients with anxiety neuroses usually get the most help..." And there

Continued on page 10

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RN news

Nurse-Educator Hits Shortage Remedies

Nurse-shortage remedies proposed by a committee of the Medical Society of the County of New York (*RN* News, February, 1960) would, if carried out, "turn the nursing clock back a quarter of a century."

So states R. Louise McManus, head of nursing education at Columbia University's Teachers College. In a sixteen-page "open letter" sent to physicians, Mrs. McManus contends that:

¶ The M.D.s' report doesn't reflect the thinking of nurses. It contains many factual errors and is of questionable value.

¶ In suggesting a "sweeping reorganization" of nursing education, the M.D.-committee apparently did so without consulting nursing educators. Its figures on schooling costs are undocumented.

¶ The committee makes a "most curious" assumption when it states that "a policy of college degrees for *all* nurses" prevails.

¶ The committee violates sound educational thinking in suggesting a coordinated program that would make the practical-nurse course the first step in the education of the R.N. This course is intended only for those satisfied with studies they can easily grasp and with goals they can easily reach.

¶ Under today's conditions, nursing education can't produce more R.N.s for the bedside until *after* it has met the need for more administrators, teachers, and specialists.

¶ The M.D.-committee implies that the nurse shortage is making the public adjust to "care that falls far short of the standards of the Nineteen Thirties." Actually, says Mrs. McManus, today's patients wouldn't tolerate nursing care such as was available then.

Ultraradical Technique Used Against Cancer

About 25 per cent of those facing death from cervical and rectal cancer could be expected to survive for at least five years if an ultraradical operation called pelvic exenteration were used.

So says Dr. Eugene M. Bricker of St. Louis, who has used the technique on some 200 patients.

The operation involves removal of all pelvic organs and wide

news

lymph-node dissection, Dr. Bricker explains. The patient is provided with a colostomy on the left side. Urinary excretion is routed through a small-bowel segment to an appliance glued to the abdomen on the right side.

Nurses Hailed as Skilled Clinical Observers

The R.N. has proved she can make skilled clinical observations and carry out techniques more difficult than some of those that doctors do. Inevitably she'll take over more of the M.D.'s functions.

This, in part, is what Dr. Richard C. Webster of Brookline, Mass., says in a report to the American College of Surgeons. He lists many M.D.-procedures that R.N.s at his plastic surgery clinic have been trained to do. Among other things, his nurses

¶ Observe and record the condition of burns, wounds, donor sites, and skin transplants;

¶ Measure palatal clefts, ear protrusions, eyelid swelling;

¶ Take certain patients' histories (often eliciting information that a doctor wouldn't obtain);

¶ Do clinical photography;

¶ Abstract and microfilm data from medical literature.

Some nurses have also shown an aptitude for correlating and interpreting clinical data, the surgeon adds. But it's mainly as clinical observers that his nurses have been

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ey, J. E.: Am. J. Obst. 77:155, 1959

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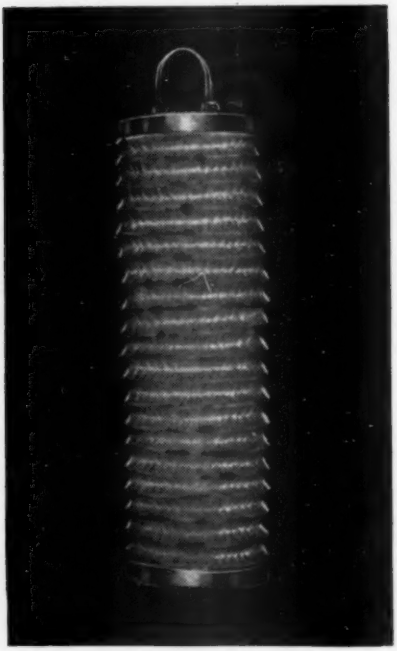
most helpful. "In this role," he says, "their eyes and ears are as good as those of our physicians."

Nursing's Founder Carried This

It doesn't resemble in the least the boat-shaped Grecian lamp used as nursing's symbol. But this is the



lamp Florence Nightingale carried at Scutari.

It's owned today by London's Royal United Service Institution, according to Dr. Warren G. Harding II of Ohio State University, writing in the Ohio State Medical Journal.

The Nightingale lamp is made of parchment, reports Dr. Harding, with top and bottom of tin. It's collapsible, and when extended, as shown, it's twelve inches tall. A candle provides the light.

New Operation Removes Clots to Save Limbs

Surgical removal of arterial blood clots can prevent the loss of a leg or an arm, reports Dr. Frank Wheelock Jr. of Harvard.

If surgery is unavoidably delayed, heparin is used preoperatively, he explains. At operation, an incision is made in the artery and the clot is "pulled out like a cork from a bottle." Then, if there is distal thrombosis in the artery, a second incison is made at the wrist or ankle, and the clot is flushed out.

The symptoms of arterial clots, Dr. Wheelock adds, are sudden pain, numbness, paralysis, and coldness in the limbs.

Symptom-Reporting Urged

Two of every five patients who die of head injuries could be saved by neurosurgery if certain symptoms were promptly recognized, reported, and action taken, says Boston's Dr. H. Thomas Ballentine Jr.

The symptoms: Persistent headache that increases in severity; inequality in the size of the pupils; nausea; vomiting; weakness in one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news

side of the body; drowsiness and gradual loss of consciousness.

If the victim is a child, says the doctor, watch especially for drowsiness. Wake the child several times during the night to make sure he hasn't lapsed into unconsciousness.

capsules

Using suppositories containing aminophylline or theophylline to treat an **asthmatic child** may cause fatal poisoning, warns a report to the New Jersey medical society . . .

Relieve the **nurse shortage** by teaching doctors' secretaries to do certain office-nursing procedures. That's the philosophy at St. Joseph's Hospital in Syracuse, N.Y., which hopes to reduce the number of R.N.s who leave general duty for office nursing . . .

Homograft rejection may occur because the recipient is sensitive to an antigenic factor in the donor, says a Belgian-American study team. The researchers suggest that, before grafting, the recipient be desensitized with injections of the factor . . .

New standards for the training of **nurse-anesthetists** require candidates to complete an 18-month (instead of the present 12-month)

news

program. The standards go int effect July 1, 1962, for existin schools. New schools establishe before that date must offer an 1 month course only . . .

Large-scale tests to find out if new borns can be effectively immunize with oral doses of **live-virus poli vaccine** are reportedly under wa at medical centers in New Yor and Cleveland . . .

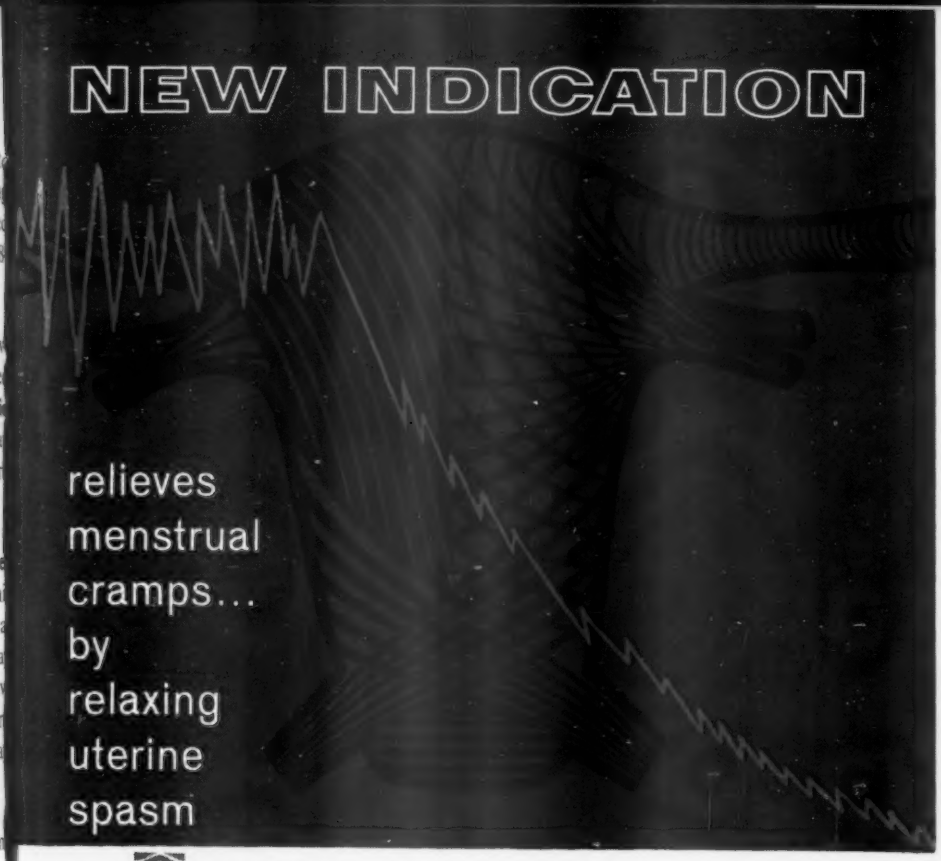
Turning an **unconscious skin dive** on his left side may help save hi life, says a medical columnist. Rea son: Air bubbles in his blood ma be preventing the blood from leav ing the right side of his hear When you turn him, the blood ma flow out through the valve . . .

Tiny cubes of placental tissue im planted in the thighs of patient affected with **peripheral vascula disease** relieve arteriosclerot symptoms for as long as two years say two Edinburgh M.D.s . . .

It's **illegal for nurses** to compoun or dispense a prescription in Mary land, even under the supervision o a doctor-employer, the state's at torney general has ruled . . .

Powdered cadaver skin speeds th **healing of burns,** a Polish scientis reports. The skin is fast-frozen be fore powdering, then refrigerate until needed. EN

NEW INDICATION



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Supplied: 10 mg. tablets, and 2 cc. ampuls containing 10 mg. (5 mg./cc.) *for intramuscular use.*

References: (1) Voulgaris, D. M.: Dysmenorrhea: Cramps or Psyche?, Scientific Exhibit, 108th Ann. Meet., Atlantic City, June 8-12, 1959. (2) Detailed reports in Mead Johnson research files. (3) Voulgaris, D. M.: Obst. & Gynec. *15*: 220-222 (Feb.) 1960.

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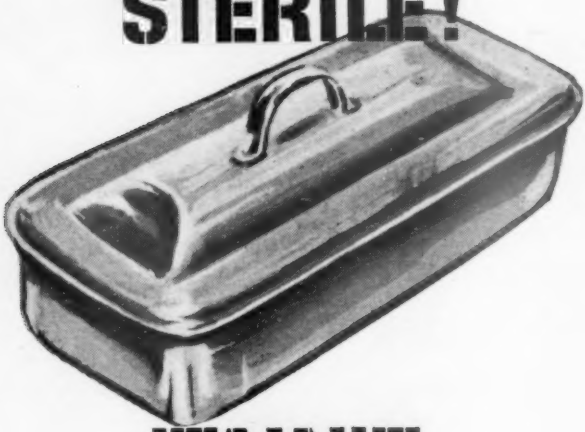

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HEMOGLOBINOMETRY: A new instrument to provide exact, authoritative hemoglobin measurement while the patient is still present has been announced. Known as the Coleman "25" Photo-Hemoglobinometer, the instrument provides on-the-spot, direct scale reading of hemoglobin concentration in whole blood within 3 minutes. Coleman Instruments, Inc. **E-2**

EMERGENCY OXYGEN UNIT: The new Lif-O-Gen Inhalant weighs only 20 ozs.—small enough to be carried in a handbag or the dash compartment of a car. Lif-O-Gen provides oxygen administration for 25 minutes. Useful for every emergency situation. Literature. Linde Co. **E-3**

STERILE HYPODERMIC NEEDLES: A new disposable, sterile-packed hypodermic needle is called Sharp-Et. The individual needles are heat sealed in tamper-proof cartridges. The cartridge is hexagonal, to prevent rolling on smooth surfaces. Literature. Randall-Faichney Corp. **E-4**

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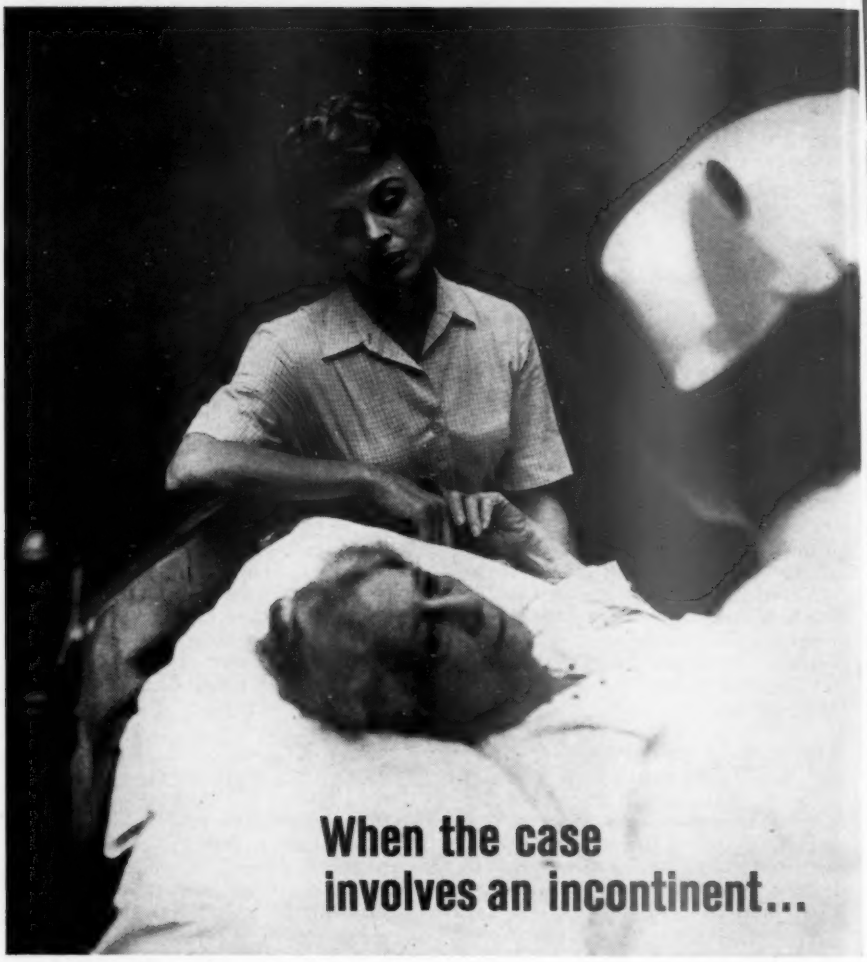

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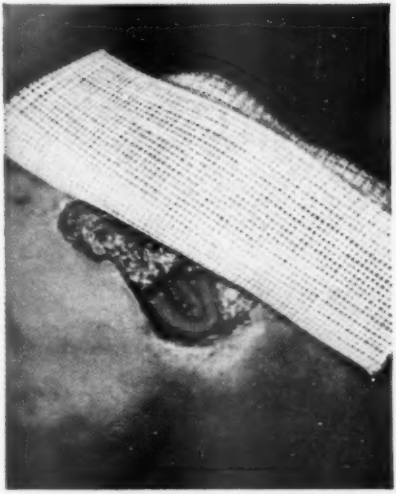

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Legal Pitfalls in PROGRESSIVE PATIENT CARE

These are the dangers to watch for if you now work —or ever do work—in a hospital that offers P.P.C.

By William A. Regan, LL.B.

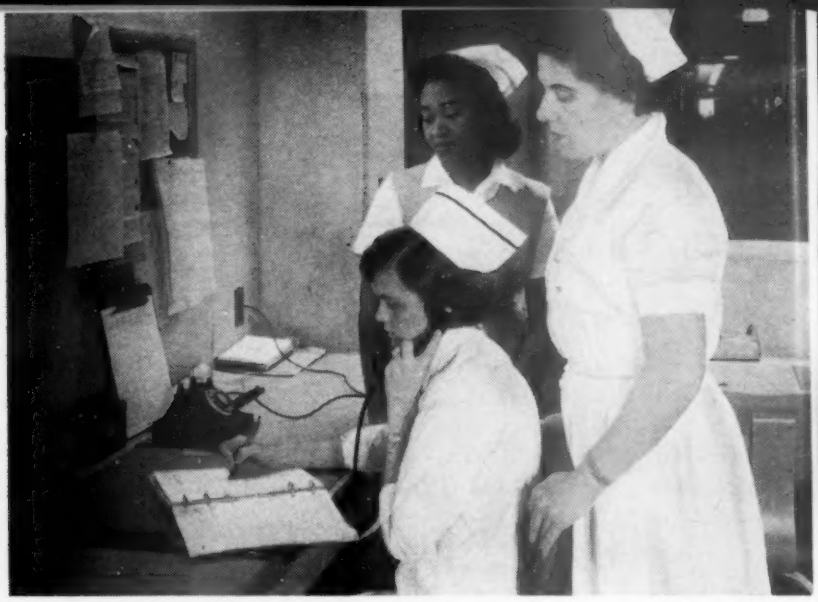
It is hoped that Progressive Patient Care will make more effective use of available nursing skills by reassigning nurses so they can give care where it's needed most.*

This is a new concept for nursing. But legally it doesn't release the hospital—*or the nurse*—from any responsibility. The hospital with P.P.C. units must still meet certain minimum standards of patient-care.

This responsibility begins when the doors swing in to admit a patient and continues until the doors swing out to discharge him. From a legal point of view, it doesn't matter one iota whether or not the hospital calls a particular wing, or section, a "minimum-care" or a "self-care" unit. The patient in such a unit is still under hospital care.

What *is* new—and legally dangerous—is this: When a hospital juggles the ratio of nurses to patients (particularly when it low-

*See "How's Progressive Patient Care Doing?," April, 1960, *RN*.



AN R.N. ON EACH SHIFT, *regardless of the type of P.P.C. unit, helps to protect the hospital and the staff from possible negligence suits.*

ers its ratio), accidents are bound to happen.

Already, the courts have had to wrestle with knotty problems of legal liability in P.P.C. accidents. The decisions made so far can be summarized in four ground rules that every nurse will want to know:

1. No hospital unit should be without on-the-spot R.N. coverage during each shift.

Recently I heard a nursing educator tell about the successful minimum-care unit at her hospital. It was called the "Special-Care Department," she said, because "minimum care" had a sinister legal connotation.

She should have called a spade a spade. There was nothing "special" about the quality of nursing care in the unit she described. Not a single R.N. was on duty during two of the three shifts. This, she said, released badly needed R.N.s for more important duties elsewhere.

After *her* talk, *we* had a talk. She was aghast when I pointed out that a single unfortunate accident while no R.N. was on duty

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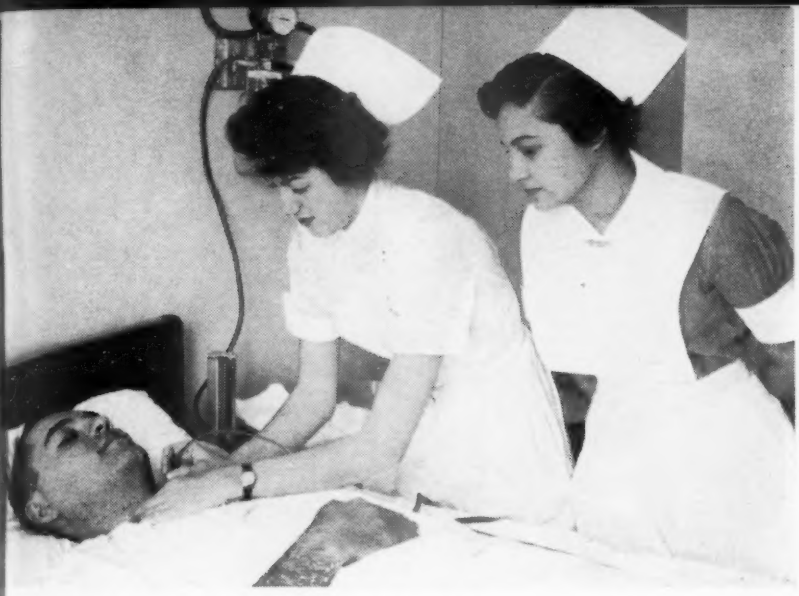
THE AUTHOR *is chairman of the International Conference on Hospital Law, legal counsultant for the Catholic Hospital Association of the U.S. and Canada, and a member of the Bar of the Supreme Court of the United States.*



A STUDENT OBSERVER *is permitted in a large intensive-care unit. But only a graduate nurse should give the actual patient-care in such units.*

could light the fuse to a disastrous negligence suit. She began to wonder if releasing two R.N.s for duty elsewhere was worth the hazard involved.

2. R.N.s in intensive-care units must be thoroughly trained and "psychologically right" for the demanding situations they face.

This means, first, that student nurses should never be used in any room where the hospital has put seriously ill patients "in periculis mortis" (in danger of death). The courts will tolerate the idea of senior students *observing* in this type of unit, provided the unit is a large one. But if it has only twelve beds or less, students should be kept out altogether.

Second, it's not enough simply to use a generally skilled R.N. in an intensive-care unit. She must be specially trained for this work.

Last year at a 300-bed hospital in Pittsburgh, an intensive-care nurse called in sick. So a competent R.N. from the pediatrics department was assigned to replace her for the day. Asked by a house officer to use some new equipment on a patient, she tried but bungled. The patient died and the hospital was subsequently sued.

Fortunately, Pennsylvania is an immunity state, so the pa-

SECURING A WRITTEN ORDER *for every medication and treatment saf*NOWIN*guards the nurse in P.P.C. units where she has broad responsibilitie*urse i

tient's relatives didn't prevail in court. But if this accident had happened in any of several nearby states, there might have been a six-figure judgment against the hospital, with a separate judgment against the nurse.

This hospital learned a valuable lesson, namely: When you hold yourself out as being able to render extraordinary patient-care, you must have the people and the equipment to do the job.

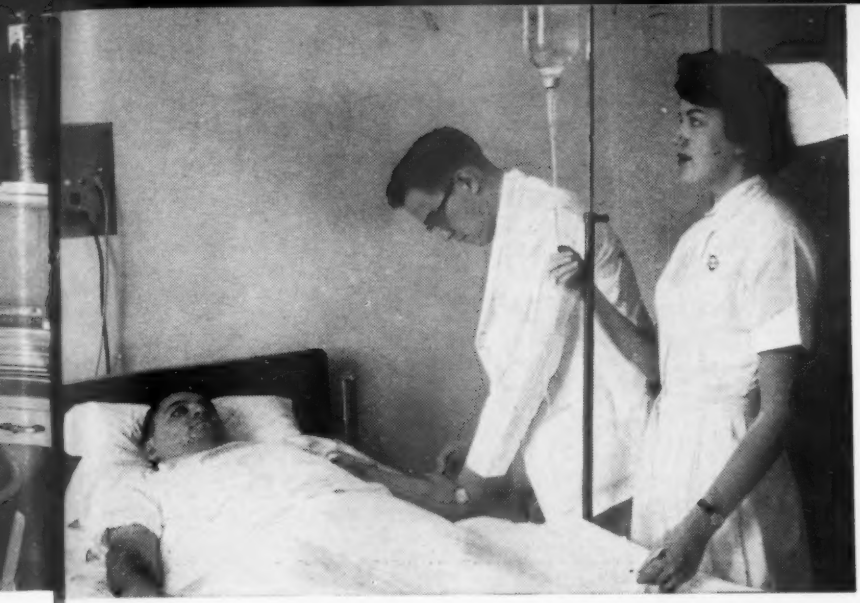
3. R.N.s may not make medical judgments, regardless of the type of specialized unit they serve in. Medication orders must always be written by M.D.s.

This holds true even when the nurse believes she has been auth osed orized to exercise limited med awsuit cal judgment. ment b

Suppose, for example, that the nu M.D. tells a charge nurse to "us refe her judgment" in administerin arries the dosage of a certain medic egally tion. The doctor believes she ers) competent to exercise such judg oesn't ment. He feels that he's compl erself menting her by showing his co 4. E fidence in the

Perhaps he is—but he's als ork u putting her in legal jeopard on of What if something happens? W ent C the M.D.'s verbal authorizati If y protect the nurse? nits, t

No, it won't. He has no aut e flirt ority to extend the limitation in erous



KNOWING NURSE-PRACTICE LAWS *of the state she works in will guide the nurse in limiting her work with such procedures as I.V. administration.*

n auth osed on the nurse by law. All
l med wsuits involving errors in judg-
ment by nurses make it clear that
that the nurse has only one function
to "us reference to medications: She
isterin arries out the *proscribed orders*
medica egally, posted or published or-
s she ers) of the physician. She
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his co 4. Every nursing-practice act
n the U.S. requires that R.N.s
e's als ork under the general supervi-
opardy on of M.D.s. Progressive Pa-
ns? Wi ent Care does not change this.
rizatio If your hospital has P.P.C.
nits, the trustees may right now
o aut e flirting with the legally dan-
tion in erous idea of having intensive-care nurses handle most I.V.s on their own.

I use the word "dangerous" advisedly. More than a dozen states forbid by statute the performance of I.V.s by nurses *except under immediate and present medical supervision.*

A county hospital in the Southwest recently discovered how dangerous nurse-administered I.V.s can be. A pregnant woman was admitted, suffering cuts and shock from an auto accident. Bleeding was stopped and shock reduced; and she was made as comfortable as possible.

Eight hours later she began

Continued on page 87

G.U. NURSING UP

EDITOR'S NOTE: *G.U. nursing has changed greatly in recent years. R.N.s in modern urological services point proudly to the many advances in treatment and in methods of patient-care, and to the improvements in equipment since their student days. These, they say, make G.U. work much more interesting and rewarding than before.*

Gone are the bedfast patients, the unpleasant odors, the hours nurses used to spend cleaning tubing and receptacles clogged with decomposing urine. Though G.U. patients, almost without exception, still require urinary drainage, changes in nursing methods and better understanding of patient-needs have helped solve many of the problems nurses used to face.

This article takes you on a visit to a topflight G.U. center. Here you'll learn about some of the new techniques and equipment while observing up-to-the-minute G.U. nursing.

By Charlotte Isler, R.N.

NG UPDATED

I sat beside the desk of Eileen Kullman, head nurse on a urological floor at St. Vincent's Hospital, New York City, while we waited for the chief of the G.U. service to arrive.

"What factors," I asked, "have caused the greatest changes in urological nursing?"

Miss Kullman thought for a moment, then said, "Improved equipment certainly gets a share of the credit. But I think the broadening of the nurse's knowledge in this field and the increasing responsibility she has been given are more important.

"The nurse is more deeply concerned with the patient as a *person*. She thinks in terms of his total needs—emotional as well as physical. She understands that the urological patient has *special* needs.

"For example, catheterization can be an unpleasant and embarrassing experience for the patient, as you know. The G.U. nurse understands the patient's feelings and makes a special effort to explain the procedure in terms he can understand. Also, she respects his sense of modesty. And she sees to it that others do, too."

At this point, Dr. Thomas F. Howley, the G.U. service chief, came down the corridor toward us. After introductions, Miss Kullman asked Dr. Howley to tell me something about Mr. M's urological condition. (Mr. M had just been admitted for a benign prostatic hypertrophy.)

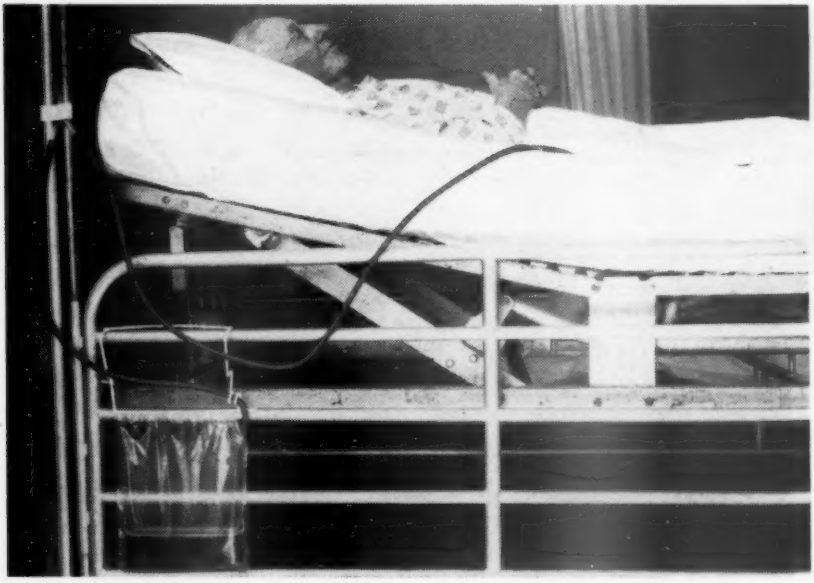
As we started for the patient's room, Dr. Howley explained: "Mr. M has acute urinary retention. This is caused by pressure

and intrusion of the hypertrophied prostate on the urethra. Urination is frequent, painful, and scanty. As a result, the bladder is greatly distended. Now we must drain it by gradual decompression, for rapid decompression might result in congestion of both kidneys with hemorrhage and shock."

When we reached the patient's room, Miss Kullman and I waited outside while Dr. Howley, assisted by an orderly, inserted a retention catheter into the patient's urethra. When he had finished, he called us in and instructed Miss Kullman to have the catheter attached to medium decompression drainage.

Miss Kullman then offered to show me how a decompression drainage set is used. The sterile package contained two lengths of tubing connected by a Y-tube. One length of tubing had a glass adaptor at the distal end.

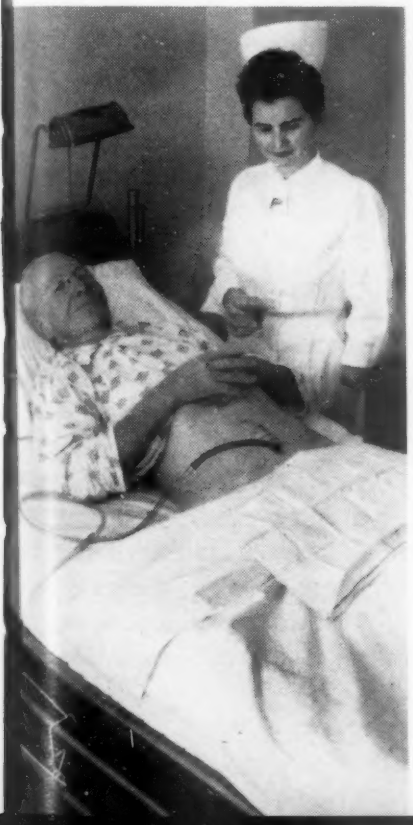
She inserted the adaptor into the catheter, taking care not to contaminate the inner wall of the catheter or the tip of the adaptor.



BLADDER DECOMPRESSION *before surgery is gradual, to prevent shock. The Y-tube (upper left) is moved up or down to regulate the urinary-flow rate.*

"New knowledge of hospital sepsis makes us acutely aware of the importance of aseptic technique today," she commented. "It's especially important in urology for the nurse to know when to use sterile technique and when she can safely use surgically clean technique. A urinary tract infection can be a serious and difficult-to-treat complication."

Miss Kullman next fastened the Y-tube, with the open end uppermost, to the bed frame (see photo at left, below). Then, she inserted the free end of the decompression set-up into a disposable drainage bag.



SUPRAPUBIC DRAINAGE *after surgery continues until the prostatic bed heals. The R.N. checks drainage easily through the clear plastic.*

"The urological nurse has to know and make use of some basic principles of physics," she commented. "Two such principles are employed here: One, a fluid will flow through a siphon in the direction of least pressure. Two, the speed of flow can be slowed by interfering with the pull of gravity.

"In this drainage set, the open end of the Y-tube permits some of the pressure exerted by the distended bladder to be dissipated. This creates a flow of urine toward the Y-tube, in the direction of less pressure. Then, by placing the Y-tube at medium height (three to five inches above the bladder), we interfere with the pull of gravity. This slows down the flow of urine, giving us the decompression we want.

"For high decompression, I'd raise the Y-tube to a point five to eight inches above the bladder. For low decompression, I'd lower it to bladder level.

"We adjust the Y-tube so that

the bladder will empty gradually over a period of twenty-four to forty-eight hours. Some urine must remain in the bladder at all times so that the bladder wall won't collapse against the catheter's opening, obstructing it."

After Miss Kullman had explained the procedure, we returned to the nurses' station until time to visit a second patient with benign prostatic hypertrophy who was then in the recovery room.

While we waited, I learned that there are several surgical techniques for removing the adenomatous growth. In the case of this second patient, the surgeon had removed the growth through a suprapubic incision. Then he'd packed the prostatic bed with a rubber drain to minimize bleeding. Finally, he'd sutured a suprapubic tube into the bladder to provide urinary drainage above the operative site.

The tube was brought out through the incision (see photo on page 41). It would remain in place until the prostatic bed had healed enough for the urinary stream to be rerouted through the urethra.

When Miss Kullman received word that the second patient was being brought from the recovery room, she suggested that I observe the postoperative nursing care. This is what I saw:

As soon as the patient is transferred to his bed, the nurse connects a length of transparent, noncollapsible polyethylene tubing to the suprapubic tube. She inserts the distal end of the tubing into a plastic drainage bag that's suspended from a bedside frame.

I noted that this new equipment is easier to assemble, and

UP AND WALKING *with Head Nurse Eileen Kullman, patient finds it easy to carry light drainage device.*

also more esthetically pleasant, than the equipment I remember handling.

The transparent bag is graduated to 2,000 cc. This, too, is an improvement. When the bag is filled, it can be emptied and then discarded. Thus the odious task of cleaning and sterilizing is eliminated.

The nurse then begins recording the patient's vital signs. She checks the dressings frequently, for hemorrhage is always a danger following a prostatectomy.

She explains to him that he may have a continuous urge to void. This is caused by the packing in the prostatic bed that usually exerts pressure on the urethra.

The doctor leaves an order to give Demerol six to seven hours postoperatively. After the nurse has administered it, the doctor removes the packing through the incision and, with the nurse's help, cleans and dresses the wound.

A scultetus binder, rather than adhesive, is used for subsequent dressings. Seepage of urine around the suprapubic tube makes frequent dressing changes necessary.

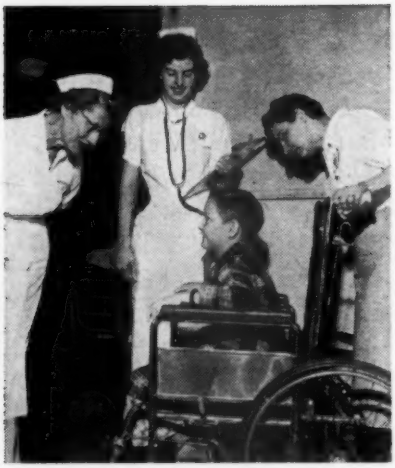
When changing a dressing, the nurse removes it with sterile thumb-forceps. Then she places a sterile towel below the wound and drops the sterile dressings (2 x 2s and 4 x 4s) on it. Next, she inspects the wound carefully, checking especially for sanguineous drainage. She washes the area thoroughly with green soap and a half-and-half solution of boric acid and alcohol. As a final step, she applies the fresh sterile dressing and secures it with a binder.

When skin irritation is present, she applies Furacin ointment or liquid. When there's heavy drainage, she uses profuse-drainage dressing sets. These packaged sterile sets include one large and two regular-size combines. The ready-made combines are great timesavers.

The nurse measures intake and output, totaling it for each eight-hour period. She records wound and urethral drainage, noting whether it's clear or bloody and the number of blood clots, if any.

"We give the patient plenty of fluids to help irrigate his bladder," Miss Kullman explains. "The doctor may order up to 2,000 cc. of I.V. fluids postop-

Continued on page 98



Rx for the Criti

These pediatric nurses have found a way to assure continuous skilled care for such patients in their hospital. Result: an improved survival rate

BY PATRICIA D. HORGAN, R.N.

In Columbus, Ohio, 11-year-old Charlie hopped a ride on the back of a passing truck. In New York City, almost at the same moment, I boarded a plane to visit Children's Hospital in Columbus.

As my plane climbed into the sky, Charlie stuck his head around the side of the truck to see where it was going. The truck entered an underpass. There was a thud. Charlie's unconscious body fell backward onto the highway.

* * *

At a bedside in the intensive-care unit (I.C.U.) of Children's Hospital, I watched an R.N. deftly thread a suction catheter into the tracheostomy tube in Charlie's throat. Nearby, an L.P.N. waited for the noise of the suction machine to subside. Then she began checking Charlie's blood pressure again.

The child had suffered a depressed skull fracture and internal injuries. But thanks to expert surgery and skillful nursing care, he seemed to be rallying satisfactorily.

What I was seeing, and what I learned as I talked with the unit's nurses, convinced me that a pediatric intensive-care unit is

the Critically Ill Child: Intensive Care

the best means yet devised to assure continuous, skilled nursing care for the seriously ill or injured child.

The Children's Hospital I.C.U. has been open eighteen months. In that time, some 440 children have been admitted. Nurses have given them more than 31,600 hours of intensive care. Result: 409 children have been discharged who might not ever have gone home again.

Before the I.C.U. was organized, Children's Hospital faced two major problems in caring for the critically ill:

¶ Many times, private duty nurses weren't available. So the hospital had to use staff nurses as specials, thus short-staffing other services.

¶ Occasionally, parents couldn't afford the cost of special care. So the hospital had to assume it.

Administrator Robert Porter asked Helen Mollencop, who's now the intensive-care unit supervisor, to study the problem of constant-care patients. ("Constant care" is the hospital's term for nursing service comparable to that given by a private duty nurse.) Miss Mollencop carefully collected data for a period of three months.

"During this short period," she told me, "the hospital supplied 2,834 hours of constant care. Because constant-care patients were scattered throughout the hospital, each R.N. had one patient only. Also, our special equipment was tied up at individual bedsides. So we decided we needed a unit where we could give special care to several patients at once.

"A new 150-bed wing was then being planned, but we didn't want to wait until it was available. We took over a six-bed ward that's conveniently near

the operating rooms, X-ray, and elevator. Also, we chose it because it has visitors' windows. Thus, parents can keep tab on their children's progress, yet not interfere with bedside care."

"Does the unit have any drawbacks?" I asked.

"Several. For instance, our storage space is limited. And only portable oxygen and suction machines are available. But the unit *is* meeting our immediate need. When the new wing is opened, we'll have a spacious, well-equipped I.C.U."

"What problem did you tackle first?"

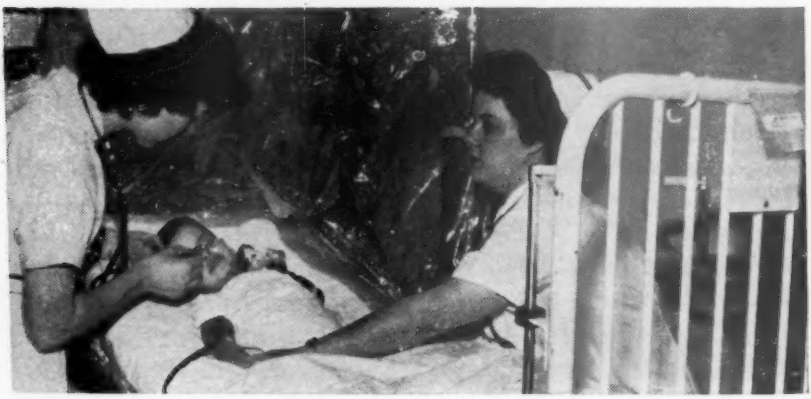
"Staffing!"

Miss Mollencop smiled wryly. "That was a tough one. We knew the four to six critically ill children in our converted I.C.U. would need maximum nursing coverage. We decided that two R.N.s would be adequate for each eight-hour shift, assisted by L.P.N.s. We also use part-time R.N.s occasionally. (For example, a nurse who works with our heart surgeon comes in to special post-op heart surgery patients.) We make sure there are two or more staff people in the unit at all times."

"Why?"

"Well, suppose a child has a convulsion. He can't be left unattended for a second. The R.N. stays with the patient while the

CRITICALLY ILL PATIENTS GET *skilled, understanding care in the Children's Hospital I.C.U. when they need it most. This R.N.-L.P.N. team does the unpleasant but necessary suctioning of a 3-year-old.*



second person gets the necessary ordered drug or notifies the doctor."

"Do your R.N.s give patient-care or do they supervise only?"

"Usually they care for the more seriously ill while the L.P.N.s care for the less seriously ill.

"The R.N.s give all medications, and they do most of the dressings. The L.P.N.s assist with such things as vital signs, checking I.V. fluids, turning and positioning of patients."

"Do you use aides?"

"Only for housekeeping and errands. We clearly define the responsibilities of R.N.s, L.P.N.s, and aides. That way we keep down confusion and help the unit to run effectively. We also spell out in detail all general regulations. For example:

"When we opened our unit, we limited admissions to children aged 2 and older. If we'd admitted younger children, our nurses would have had to use gown technique. This isn't practicable when they must move quickly from one patient to the next.

"Soon some doctors began insisting that children were 'almost two' who were actually as young as one and a half years! So we changed our regulation to the more specific term, twenty-four months. If we'd done this from

PARENTS AND PATIENTS GET *reassurance from seeing and talking to each other through the I.C.U.'s window. Here Helen Mollencop, unit supervisor, pushes the bed close so that Ronald can hear Mom and Dad.*

NURSES THEMSELVES GET *a rewarding satisfaction from receiving the cheerful thanks of such patients as Craig, here paying a thank-you call on Miss Mollencop (at left) and Head Nurse Martha Schorr.*

the first, we'd have saved much time and argument."

"What if a child under two needs constant care?"

"In that case, he's admitted to one of the other units. He immediately goes on constant care, with the usual infant precautions. Right now some ten children are receiving such care."

"Have you run into any especially difficult problems?"

"Well, our 'No Visitors' rule may be classed as such. We enforce it *strictly* for several reasons.

"First, our unit is small and very busy. If we permitted parents and others at the bedside, they'd greatly impede our work. Second, most of our patients are too ill to cope with visitors—even their parents. Finally, visitors are upsetting to some children.

"The viewing windows help

solve this problem. When a child's condition permits, we move his bed to a window so he and his parents can see each other and talk.

"Naturally, the children miss their parents. They often cry after seeing them. We do our best to make up for the lack of parental comfort by giving the youngsters lots of T.L.C. This often works wonders.

"Continuity of nursing care is also important. With the *same* nurses taking care of a child throughout a critical period—rather than many new and strange nurses—he's less likely to become confused and upset.

"An I.C.U. is of benefit to parents, also. They know their child is getting the best possible care when he needs it the most. Too, they save on nursing costs. Their child gets round-the-clock care for $1.75 an hour."

Do the Nurses Like It?

"Does the I.C.U. benefit your *nurses* in any way?"

"Let's ask them," Miss Mollencop suggested.

As we entered the unit, Head Nurse Martha Schorr was just finishing a hypothermia pack on a 5-year-old boy.

"We use this hypothermia technique to reduce the metabolic rate and the oxygen needs of a febrile child," Miss Schorr explained. "First, we place him on a water-cooled hypothermia mattress. Then we cover him with a sheet and pack ice-filled plastic bags about his body. The bags mold easily to the body's contours. We give him alternate doses of Thorazine and Phenergan, q. 20 minutes as ordered, to control shivering and restlessness. We keep the reduced temperature within a range of 90 to 93 degrees Fahrenheit.

"It's inspiring to see a sick child improve after this treatment. In fact, watching our patients recover is one of the real satisfactions of I.C.U. nursing. We work hard, but we get to *see* the results of our work and to know that our care has really made a difference."

I next talked with "Babs" Dresher, a graduate of a collegiate program.

"I came to Children's Hospital," she said, "because I wanted to get sound bedside nursing experience. Also, I like children. You can imagine how pleased I was when they assigned me to the I.C.U.

More▶

"In the short time I've been here, I've cared for more kinds of patients than I would have seen in years in most situations. For instance, I've had children with biliary obstruction, multiple fractures, poison ingestion, and diabetic coma. I've cared for youngsters who've undergone everything from heart surgery to craniotomies.

"I've also been able to put my communication skills to good use in comforting my patients and reassuring their parents. I surely recommend a children's I.C.U. to any young graduate who wants to learn and grow in her career."

As I prepared to leave Children's Hospital, Miss Mollencop and I passed Charlie's bed.

"Feel better, Charlie?" she asked.

"Yes, Miss Molly," came his hoarse whisper. His pale, round face screwed up in a courageous smile.

When we'd passed out of earshot I asked, "Do you think he'll make it?"

"We hope so," Miss Mollencop said. "We're giving him the best care we know how to give, day and night." END

Neighborly diagnosis

My new neighbor insisted on telling me her symptoms, even though I did my best to stop her.

"My worst pain is here," she said dolefully, massaging her massive bosom. "The doctor says it isn't heart trouble. What else could it be?"

I didn't want to offer a diagnosis, but neither did I want to appear stupid. So, after a moment's thought, I came up with a word I hoped she wouldn't understand.

"Maybe it's flatulence," I suggested.

The woman beamed. "Well!" she exclaimed. "I knew that doctor was wrong. He said it was gas!"

—MARY M. MORABITO, R.N.

For each previously unpublished anecdote accepted, RN *will pay $15 to $25. Address: Anecdotes,* RN, *Oradell, N.J.*

When Your Patient Asks:
Do I Have Cancer?

BY ILSE WOLFF, R.N., M.A.

Just what do nurses say to the fearful patient who asks if he has cancer?

Do they reassure him, pretend ignorance, or pass the question on to the doctor?

There's no way of telling what *all* nurses say in such a situation. But here's approximately what 200 nurses say, as shown by a recent *RN* survey:

¶ Ten per cent say: "Of course you don't have cancer!"

¶ Fifteen per cent say: " I really don't know. No one has mentioned anything about it to me."

¶ Seventy-five per cent say: "You'll have to ask your doctor." (Many of these add, defensively: "A nurse isn't allowed to diagnose an illness.")

Which answer is preferable? Let's examine them, one by one.

The nurse who attempts to calm her patient with a flat "no" may think she's helping him. Actually, she feels attacked and threatened by this question, so she wards off her discomfort by an emphatic denial. By this act, she abandons her patient and regains her own sense of well-being at the patient's expense.

The nurse who pleads ignorance also lets her patient down. Her evasive answer heightens

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THIS ARTICLE *is the first of a series that will suggest appropriate answers for a nurse to use when her patients ask difficult questions. The author is Mental Health Nursing Consultant to the Connecticut State Department of Health, Hartford.*

the patient's apprehension. He feels alone and rejected.

The nurse who refers her patient to the doctor is on sounder ground. Her unwillingness to answer a question that's in the doctor's province is legally and professionally justified. But all depends on how she does this. The *way* she answers may confirm, or even heighten, the patient's fear. If she replies quickly, "Ask your doctor," she may just as well say, "Yes, you have cancer." For that's what her curt answer implies.

How, then, can she answer this difficult query?

If she's wise, she realizes that there are no magic words to resolve the situation painlessly. She knows that the words she chooses are effective *only* when they reveal a true sense of understanding and kinship, of respect for the patient and for the suffering he endures.

Ask a Question

So she tries first to find out what the word "cancer" means to this particular patient. She knows that distorted ideas about the disease are common. Does her patient think he'll have unbearable pain? Is he worried about odor? Rotting away? Mutilation?

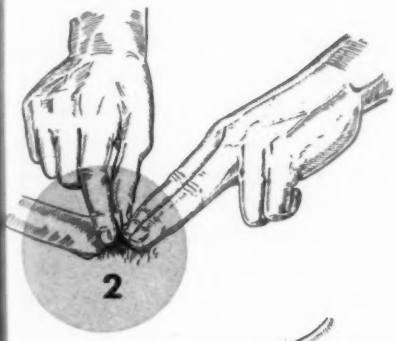
To gain time, she may parry his question with a counter-question: "You're afraid you have cancer?" Or: "What makes you ask?" Or: "Is that what the doctor told you?"

What You'll Gain

As she helps her patient to express himself, she learns about his particular concern. She places herself in a better position to respond helpfully and constructively.

She may learn whether he harbors any misconceptions that can be cleared up. Or, she may discover that he already knows that he has cancer. Thus she may extend the human closeness and fellowship for which, in a roundabout way, he is asking.

Once she has gained this understanding of her patient, she will know what to tell him. Generally, when a patient asks, "Do I have cancer?" the astute nurse will avoid a direct answer in favor of an exploratory one. For only if she understands can she be of help to others. Understanding, interest, and human warmth are, in the final analysis, what the patient wants most. END



Removing the Patient From the Tape

BY LUCILE HOERR CHARLES, PH.D.

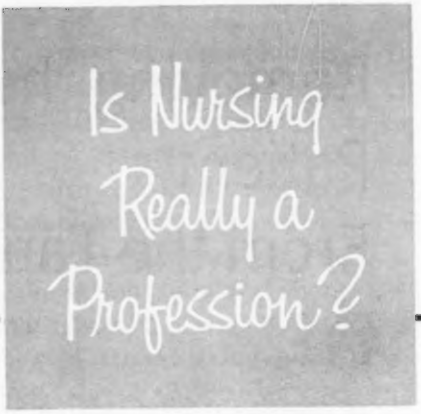
"Just rip it off!" most R.N.s are likely to say when asked the question, "What's the best way to remove adhesive tape?"

Ripping it off, though speedy, can be extremely painful, as many patients will testify. Hair —and sometimes skin—peels off with the tape (see Figure 1).

For a painless removal, just reverse your thinking and slowly remove the patient from the tape. Here's how to do it, as shown in Figures 2 and 3 at the left.

Figure 2: Press firmly on the skin and gently lift a corner of the tape. *Figure 3:* Continue to press on the skin and to lift the tape, slowly and gently, till all is removed. END

Adapted from GP *with the permission of The American Academy of General Practice.*



How Nurses De

EDITOR'S NOTE: *Nursing is* not *a profession, charges Eli Ginzberg,* PH.D., *Professor of Economics at the Graduate School of Business, Columbia University, and director of the University's Conservation of Human Resources Project, in a recent interview with an* RN *editor (see January and February, 1960, issues). He reasoned thus:*

(1) The two- and three-year nursing school curriculum is too limited to qualify the R.N. as a professional. (2) College and university programs emphasize administration above nursing practice. (3) Nursing research is in its infancy. (4) Nurses, as ancillary workers, haven't the independence of truly professional workers. (5) There are too many R.N.s for the economy to support at a professional salary level.

But, said Dr. Ginzberg, nursing can become *a profession if its leaders will take the following steps:*

(1) Select well-qualified nurses and help them to get employment at professional tasks and at a professional salary level. (2) Set standards by which to measure the performance of this élite corps. (3) Limit the corps to no more than 70,000 nurses. (4) Redefine the present R.N. as a technician. (5) Consider auxiliary workers below the R.N. level as useful co-workers, not as competitors. (6) Enlist the help of hospital administrators, educators, and doctors in the effort to achieve professional status.

Readers' reactions to Dr. Ginzberg's thesis were many and varied. Here, in brief, is a cross-section.

ses Define Their Own Status

"Dr. Ginzberg is getting hundreds of nurses' tempers up!" correctly guessed Ruth Caldwell of Westmont, Ill. Indeed, many comments received by *RN were* slightly on the hostile side.

"He's a tongue-in-cheek friend of the nurse," charges Mabel M. Linkous of White Plains, N.Y. Adds Evelyn G. Leffler of Salem, Va.: "Good-by to a beautiful friendship!"

Other readers attack Dr. Ginzberg on grounds that an outsider isn't qualified to sound off about the R.N.'s problems.

Says Margaret McCabe of Detroit: "Consulting an economist about nursing is like picking any port in a storm." Pauline Schwartz of the same city asks: "What's wrong with nursing today? For one thing, nursing leaders listen to the advice of ill-qualified people like this economics professor!"

But many nurses applaud Dr. Ginzberg. "Congratulations," says E. Holloway of Concord, N.H. "You've cut the red tape, hacked away the underbrush, and gotten through to reality. It didn't even hurt when you stepped on my toes!"

Educator Mary Louise Brown, Yale School of Nursing, says: "Dr. Ginzberg raises questions that I hope nurses will soon begin to try to answer." Marguerite E. Hemment, Lake Geneva, Wis., adds: "He places the nurs-

ing crisis in true focus. I'm glad that educators outside the nursing world are attempting to help us solve our problems."

Some nurses confess to mixed emotions. "I was boiling mad at first," says Marjorie E. Reed, Long Beach, Calif. "Then I decided that criticism is good because it brings out new ideas."

Other R.N.s, such as Myrna S. Jaspan, Milton, Mass., agree only in part. "Some modification of Dr. Ginzberg's argument is necessary," she says. "The nurse *does* need a college education. But combining liberal arts and nursing won't make a good nurse or a well-rounded person. The nurse must train for nursing and then go to college—or, better still, go to college and *then* train for nursing."

So much for the general reaction. Now what do nurses think of Dr. Ginzberg's *reasons* for believing that nursing isn't yet a profession?

Take first his statement that the two- and three-year nursing school curriculum is too limited to give R.N.s needed general background. This drew many denials.

My Most Unforgettable

Mikie, a 4-year-old darling with shiny red-gold curls, lay helpless on his small bed. His bewildered look and pleading eyes pierced my professional reserve the moment I saw him. From then on, my heart joined my mind and hands in the battle for his life.

This was my first day on the polio ward. It was one of those catastrophic summers before Salk vaccine. Mikie had polioencephalitis. His chance for survival was small. As for me, my only protection was caution and prayer . . . I tried to put fear from my mind as I ministered to him.

The long, climactic battle began when he entered the respirator, with his tracheostomy tube

Julia Flores of Albuquerque, N.M., says: "Our three-year school teaches *total* patient-care, including the sociological, psychological, and physical needs of the patient."

Add Violet Zinser and Patricia Daria, both of Cincinnati: "We differ with the point that the R.N.'s education equals only about a year of college study! How long has it been since Dr. Ginzberg looked at the program of a three-year school?"

Miss Flores also comes to the defense of college and university nursing programs which Dr. Ginzberg says often emphasize administration above nursing practice: "Most of our university nursing students," she says, "minor in one of the social sciences. They're quite aware of the patient's emotional, social, and cultural needs."

Dr. Ginzberg's remark that R.N.s lack the independence of truly professional workers drew less fire. In fact, many of the nurses who responded agree with him. Alex Bauerle of Cato, N.Y., explains:

"Doctors, lawyers, and most

Continued on page 94

e Patient

BY GUYRETTA INGLE REVELS, R.N.

in place. The almost-continual suctioning he needed had to be done with utmost care. Each suctioning period, I knew, must be brief enough to prevent depletion of oxygen yet long enough to keep him from strangling on his secretions. The catheter's depth had to be checked constantly to prevent its injuring the delicate tissue.

As I carried out the procedure —time after time, day after day —my mind prodded me: "Clean the cannula often. Watch the oxygen rate. Check the respirator's positive-negative pressure. Remember the vital signs, the I.V. fluids, the times for medications and treatments . . . Smile. Reassure the patient. *Pray!*"

The days went by in a night-

marish blur. Crisis followed crisis. Whether I was on duty or off, the whish of the respirator, the hum of the suction machine, the hiss of escaping oxygen echoed constantly in my ears . . .

Now Mikie was five years old. Though he spent his birthday in the respirator, it was a joyous time. He was at last improving.

Complete Dependence

By then I could tell from his slightest gesture—often from just his facial expression—what he wanted me to do for him. But this relationship created a problem when he finally left the respirator:

It was too much trouble, he decided, to hold his hand over the tracheostomy tube and talk. It was more fun to order me around with gestures. I did my best to change his mind; but I just couldn't get Mikie to say a word.

One day, as I started to feed him, he indicated that he wanted something on his cottage cheese. "Salt?" I asked. He shook his head. "Pepper?" Again, no. "Milk?" Another no.

By now I had guessed it was sugar he wanted. But I didn't reach for it. This, I decided, was a good time to fight him to a standstill.

"Mikie," I said, "only stupid people never talk. So you must be stupid."

Instantly his hand covered the end of the tube. "I'm not!" he exclaimed. "*You're* stupid!"

As I raised my eyebrows and sat back, he suddenly realized that I'd made him talk. Did he get angry or sulk? Not Mikie. He grinned broadly and said, "Sugar, please."

Thereafter we spent many happy hours together. Finally, the day came that I'd worked and prayed for. He was discharged with only minimal damage.

Complete Independence

For a time I saw him often. Too soon, it seemed, his red-gold curls were replaced by a small-boy haircut and his shy dependence turned into boyish aggressiveness . . .

His mother and I still exchange Christmas cards. Occasionally I get out Mikie's picture and recall our frantic battle against polio. Though I'll never have children of my own, I'll always be happy that I could help to give one boy life. END

Educated or Dedicated?

BY MARGARET DAVIS STOKES, R.N.

Providing a sound basic education for student nurses is good. Providing a college education is even better. But in our efforts to improve the level of nursing education, are we forgetting that something *more* than knowledge and skill is required?

While talking to a student some time ago, I referred to nursing as a calling that requires dedication.

"Boy, are you old-fashioned!" said the student cynically. "Nurses aren't dedicated any more. They're educated!"

As time went by I saw that this girl was at least partly right. For many nurses today *do* stop short of doing things for their patients that truly dedicated nurses would do for them.

For instance, there was the R.N. who rushed up to me and said with annoyance: "The terminal patient in 107 wants someone to read the Bible to him. I've called his

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THE AUTHOR *is a private duty nurse in Sacramento, Calif., who is studying for her degree.*

minister, but the minister is out. Will you do it?"

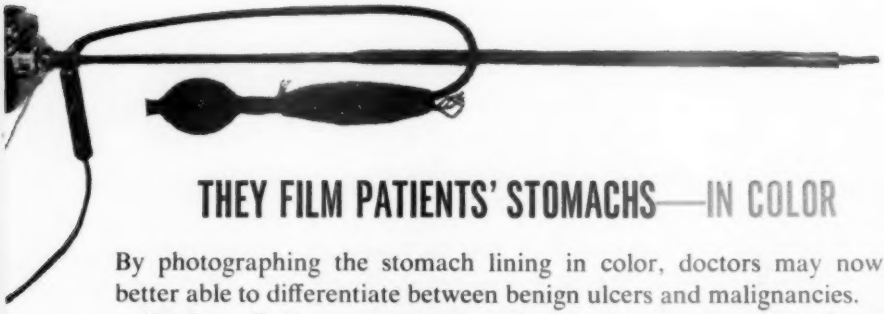
"Perhaps he'd rather have *your* help," I suggested.

She shrugged. "Maybe. But Bible-reading isn't my job."

She had a point. Ordinarily, it isn't. But she ignored a much more important point:

Nursing, like medicine and the ministry, is a humanitarian profession. It's concerned with human life and the human spirit. So the true nurse does whatever is necessary under the circumstances to ease pain, to give comfort, and to lend courage.

If this means reading the Bible



THEY FILM PATIENTS' STOMACHS—IN COLOR

By photographing the stomach lining in color, doctors may now be better able to differentiate between benign ulcers and malignancies.

Dr. Ivan C. Keever of Northwestern University, one of the first U.S. doctors to use the new technique, is shown here with Barbara Borchers, R.N., of Chicago's Passavant Memorial Hospital.

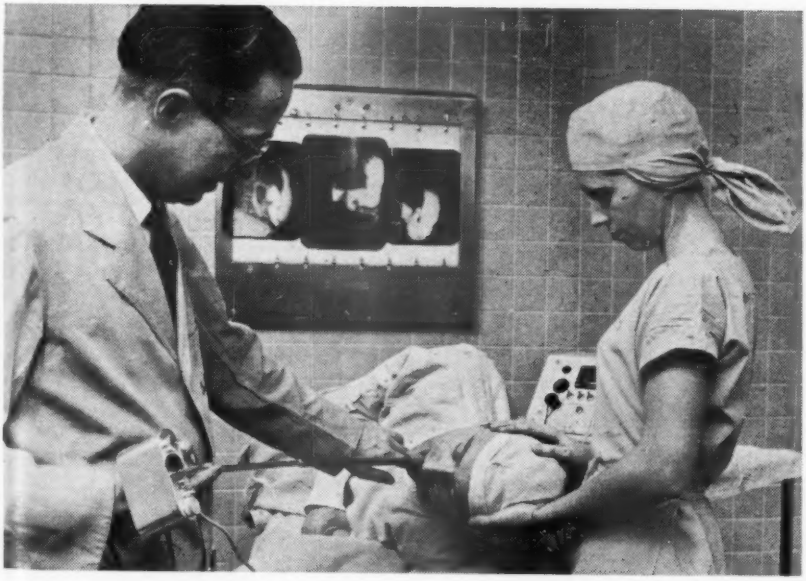
To film a suspected lesion, the M.D.-R.N. team uses a flexible gastroscope (shown above) with a special 35-mm. camera at the viewing end. Encased in the gastroscope's plastic tip are the usual small tungsten bulb plus a powerful electronic flash bulb.

The M.D. inserts the gastroscope through the patient's mouth (as shown at right). He turns on the small light, looks into the camera, and focuses on the area to be filmed. When he presses the camera button, the electronic flash lights up the stomach's interior for one-thousandth of a second, reflecting the image through the scope and to the film in the camera. The technique has been used successfully on 500 patients, M.D.s report. END

to her patient, the nurse may still try first to get a minister or a chaplain. But if she can't get one, it's up to her to read the Bible to her patient herself.

Am I being "old-fashioned" when I make such a statement? I think not. Educators today repeatedly urge the nurse to establish empathy with her patient, to project herself into the patient's situation. This is fine. This is exactly what our profession needs. But I wonder if these educators are aware of a second point that's equally important:

Empathy isn't something learned in a classroom. Empathy



stems from a desire to give of oneself to someone or some thing. In other words, empathy is a direct result of spiritual dedication.

We can fill a girl's mind to the brim with technical knowledge. But if she isn't dedicated to start with—and if she doesn't become *more* dedicated along the way—she'll never achieve empathy with her patients. And if she doesn't develop empathy, she'll never become a nurse in the truest sense of the term.

Many changes in nursing have caused controversy. But there's no room for controversy over education vs. dedication. Nursing needs both education *and* dedication. Not until enough dedicated girls become well-educated nurses will we have done our job. END

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legal pointer

QUESTION: *An R.N. often has to state that a patient is conscious or unconscious, in "good" or "poor" condition, etc. Isn't she exercising medical judgment illegally when she makes such statements?*

ANSWER: Not if she makes them orally or in writing to *physicians only*. The typical definition of registered professional nursing says that an R.N. may observe symptoms and reactions. Hence, she may also report such to an attending M.D. The M.D. understands that her report is an opinion based upon observation. It is *not* a medical judgment arrived at after examination of the patient.

DO YOU HAVE A QUESTION *about some legal aspect of nursing? If so, send it to William A. Regan,* LL.B., *care of* RN. *He'll select questions for reply on the basis of their general interest. None can be acknowledged or returned.*

Chemicals AGAINST *Cancer*

BY MORTON J. RODMAN, PH.D.

Encouraged by recent advances in cancer chemotherapy, many doctors now think that drugs are one of our best bets against cancer. The Government, too, is betting on anticancer chemicals. It's pouring millions into research in this field.

Yet it's doubtful that drugs have ever cured a single case of cancer.

Actually, the only real way to cure a malignant tumor is to detect it early and root it out with surgery or X-rays. These methods alone, if fully applied, could save half the 450,000 people who will become cancer patients this year alone.

So why all the new interest in drugs for treating cancer? For this reason: Chemicals offer the only hope to the other half of this yearly crop of cancer victims who are doomed to die because neither surgery nor radiation can reach their malignancies. For *only* chemicals can seek out and destroy cancer cells scattered throughout the body, beyond the reach of the surgeon's scalpel and the X-ray.

In the past dozen years, drugs of real value in treating such patients have been found. For in-

THE AUTHOR *is Professor of Pharmacology at the College of Pharmacy, Rutgers University, Newark, N.J.*

stance, several classes of chemicals now available help keep patients with breast, ovary, prostate, or lung cancer comfortable for long periods. Other chemicals are frequently used to lengthen the lives of children with leukemia.

So hopes are now high that drugs which will actually *cure* cancer will someday be found in one of the following families:

Cytotoxic (cell-poisoning) or, more technically, *alkylating agents*. These are certain molecules that attach themselves by means of chemical groups (alkyls) to the nucleic acids in cancer cells and in some normal tissues. This action keeps cancer cells from reproducing. So they die and break up much as they do when attacked by the destructive rays that radioactive substances give off.

Antimetabolites. These chemicals are closely related to substances that cancer cells normally absorb for food. But the antimetabolites have no food value. So, if the cancer cells can be fooled into taking up this related chemical, they'll starve for want of food substances.

CYTOTOXIC OR ALKYLATING AGENTS USED IN COMBATING CANCER

Entries on this list start with the official or generic name of the drugs, followed in parenthesis by trade names and/or synonyms.

Drugs in Clinical Use

Busulfan, N.N.D. (Myleran)
Chlorambucil, N.N.D. (Leukeran)
Cyclophosphamide (Cytoxan)
Mechlorethamine HCl, N.F. (Mustargen, nitrogen mustard)
Triethylene melamine, N.N.D. (TEM)
Triethylene thiophosphoramide, N.N.D. (Thio-TEPA)

Experimental Drugs

Atabrine mustard
Chloroquine mustard
Diepoxypiperazine
Nitromin
Phenylalanine mustard
Uracil mustard

Hormones (such as the sex and adrenal steroids). These change the chemical environment of cancer cells in ways that hinder their growth.

Antibiotics. Some of these natural chemicals, it has been found, keep tumors from growing.

* * *

Now we'll consider the cytotoxic (or alkylating) agents in some detail, reserving the other three classes of chemicals for future consideration.

Mechlorethamine

The first chemical of all to work well against cancer was mechlorethamine (Mustargen), also called nitrogen mustard, discovered during World War II. It's related to the original mustard or "blister" gas that was used by the Germans late in World War I.

How can such a poison-gas derivative help cancer patients? Mainly because the rapidly growing cancer cells take up this killing chemical more quickly than normal tissues. This sometimes results in dramatic remissions—especially for patients suffering from lymph-gland malignancies such as Hodgkin's disease. And it occasionally relieves the symptoms for patients with some kinds of lung cancer.

But some drawbacks and dangers have limited the use of mechlorethamine. For instance: Fast-growing but noncancerous body tissues, such as bone marrow and mucous membrane, also take up nitrogen mustard. And since the solution is highly irritating, it must be administered with great care. Even then, unpleasant side effects and dangerous reactions—such as nausea, vomiting, bleeding, and a drop in white blood cells—are common.

Recently, several new compounds have been introduced that are claimed to act more selectively on certain types of cancer. But none of these is completely free of toxicity, especially when heavy doses are needed. To overcome this drawback, doctors are trying new ways of pinpointing the action to specific cancer cells.

Cyclophosphamide

The latest chemical of this class is cyclophosphamide (Cytoxan). According to German M.D.s who first tested it, cyclophosphamide works best against

Continued on page 90

My Love Affair With Two Nurses

It all began when I turned a jeep over on myself and broke some ribs, put a kidney out of commission, and tore my diaphragm loose from its moorings. The place was central Italy; the date, July 11, 1944.

After a night in an observation ward and forty-eight hours in a shock ward, I was brought into a dirt-floored tent full of Army cots. On each cot was a blanket or two, a folded blanket for a pillow, and a soldier.

And there was the nurse!

My first impression of Ruth never changed: She was everywhere at once—not rushing around to hide incompetence, but moving rapidly on steel springs to get things done.

When they put me on one of the cots, Ruth said firmly, "This man has to have a bed." The ward boys assured her there were no beds in this evacuation hospital. She in-

By John N. Winburne

sisted that they get one somewhere.

They got one—a bed with sheets on it (sheets, mind you, in that world of scratchy, woolen blankets).

Then she said, "I want a pillow for him." You'd have thought she was asking for a miracle. A pillow? A real honest-to-God pillow? Impossible!

"Get me a pillow," Ruth said again, "even if you have to steal it from the colonel's bed."

So they got her a pillow—one with a smoothly ironed pillowcase on it; and it was sheer bliss to lay my head on.

Well, that's how Ruth was: She got things done.

She had about twenty of us to take care of, and she got around to each in turn. When she was at my bed, I was the most important person in the hospital. When she got to the fellow in the next bed, he became the most important.

Besides everything else wrong with me, I had pneumonia. They

GOODWILL PROGRAM BRINGS FOREIGN NURSES TO U.S.

If substantial numbers of foreign graduate nurses came to the U.S. for study and work, would international understanding and goodwill improve?

Staff members at Morningside Hospital in Los Angeles believe it would. So they've set up a program that gives such nurses financial help.

Their first two beneficiaries are English-speaking Keiko Yamaoka (left) and Setsuko Kokubu. Both girls, shown here at Morningside, were honor students at Japan's Kitosato Institute. They'll work in all departments during their two-year stay. When they're finished, the hospital will replace them with two more foreign graduate nurses.

"The girls are making a fine impression," says Leonard W. Days, Morningside's administrator. "We recommend this program to other hospitals." END

put an oxygen mask on me, but I promptly took it off. I was not quite in my perfect mind, as King Lear put it.

So they inserted a nasal catheter and taped it to my nose and forehead. But when the oxygen tank beside my bed started hissing, I turned the thing off.

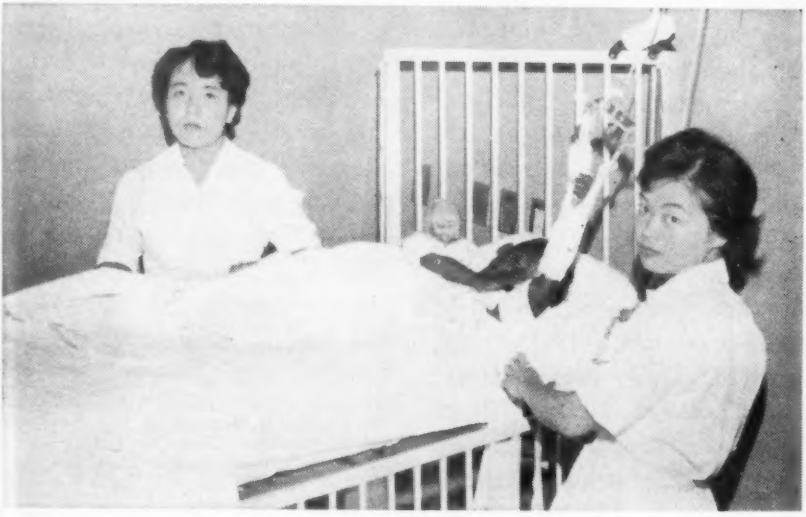
They thought I couldn't hold my water (I could). So they hooked me up to the plumbing. I unhooked myself.

All in all, I must have made a nuisance of myself.

But Ruth was always there when I needed her.

"Mr. Winburne," she'd say, "please don't do that." Or, "Mr. Winburne, please stay in bed." Or, "Mr. Winburne, I just got you all fixed up and now look at you!"

In my better moments I joined the others in telling Ruth how pretty she was (she was gorgeous) and what a nice figure she had (it was superb). We asked her where she had been all our lives, and could we come back



and date her when we got well. She laughed and sort of danced from bed to bed and told us we were all wonderful . . . The days passed quickly because of her.

His Other Love

The other love of my bigamous affair was as different from Ruth as she could be. "Danny" Deever was plump, slow, methodical; but she had a sense of humor and a sense of humaneness and a touch of whatever it was I needed. Night after night, from 7 to 7, she made the long hours bearable.

After Danny got the others bedded down, she had her night's work cut out looking after me, what with blood or plasma coming into one of my arms and glucose into the other and both arms tied to padded boards.

"My, but you're slow tonight," she'd say, and I'd laugh—not really because what she said was funny, but because she wanted me to be as cheerful as she was.

One night when she was giving me a penicillin shot, the needle bent while it was in my shoulder. Danny worked and worked to get it out. "It's all right," she kept telling me. "I know I can get it out." She did, of course, after a lot of trouble. We laughed about that too.

Another night, when I woke suddenly from a nightmare, I saw her sitting at her desk beyond the darkness, working on her records by the light of an absurd little 25-watt lamp. "Danny," I said, and she said, "Yes, Mr. Winburne?" And I went back to sleep because Danny was there.

Strangely enough, I don't remember what Danny looked like. If I were to meet her on the street now, with no one else in sight, I wouldn't recognize her. But if I were in a hospital bed at night, with the lights low, and she came to me and put her hands on me and chuckled and said, "You're feeling better, Mr. Winburne?"—well, I'd know her.

Where Are They Now?

Ruth Gifford was from Missouri, but I've lost her address. I never knew Danny Deever's address—or what her real first name was. I'd like to know. I'd like to write to both my loves. But then, of course, I have—here. END

THE AUTHOR *is Assistant Dean of the Basic College, Michigan State University of Agriculture and Applied Science, East Lansing, Mich.*

How We Insure Peace In Our O.R.

Nurses' complaints deserve as much consideration as those of surgeons, says this administrator

By the Reverend Carl C. Rasche

Nowhere in the hospital is smooth teamwork more important than in the operating room. Yet far too often the O.R. is roiled by temper outbursts and other signs of friction. Most nurses can cite examples ranging from the sarcasm of a resident to clamp-throwing by a surgeon.

It's no wonder, then, that hospitals want to resolve doctor-nurse misunderstandings before they erupt in the operating room.

But some hospitals use only halfway measures to maintain peace. They listen to surgeons' complaints but pay little heed to those of nurses. They fail to realize that nurses' complaints—as passed on through the O.R. supervisor—are often equally important and equally helpful.

At Deaconess Hospital in St. Louis, where I'm the administrator, the O.R. supervisor gets the same hearing a doctor gets. For instance:

Suppose a surgeon keeps insisting he *must* have his favorite scrub nurse, even when this means taking her away from other assignments. The O.R. supervisor talks the matter over with the doctor. If he won't listen

THE AUTHOR *is administrator of Deaconess Hospital, St. Louis, Mo.*

to reason, she goes to the nursing director. The director takes the problem to the administrator, who then confers with the chief of surgery. There a decision is made—or, if necessary, the problem is passed on to the medical administrative committee, or even to the hospital's board of trustees.

In every case the matter is decided through organizational channels and in a way that will benefit the patient. In fact:

The welfare of the patient is always our major concern.

Take the problem of tardiness, for example. If a surgeon repeatedly arrives so late that he jeopardizes his patients' welfare, the O.R. supervisor may call this to his attention directly. But if she believes her action would cause an argument, she refers the matter through channels. Sometimes a nurse may receive a tongue-lashing for her adherence to rules. But for the good of her patients, she bears this with fortitude.

Here are other "doctor problems" the nurse can solve by referring them through channels:

The case-switcher: Dr. A has a hysterectomy scheduled for 10 A.M. At 9 A.M. he calls and says he'll do a D. & C. at 10 A.M. instead. Will Miss X, the O.R. supervisor, please advance the hysterectomy to 11 A.M.?

Since this is not an emergency situation, Miss X protests. She says she'll do it only if the chief of surgery agrees that she should for the patient's sake. This usually resolves the problem.

If Dr. A seldom asked for a schedule change, Miss X would be more understanding. But Dr. A is a chronic switcher. So she makes a mental note to refer the problem for general review to the nursing director.

The contaminator: Dr. B apparently thinks he's germ-free. He ignores "No Smoking" signs. He may even show up in the O.R. in his street clothes.

The supervisor is on firm ground in this instance. For the sake of her patients, she insists that the rules be kept. If Dr. B won't cooperate, she reports him to the nursing director, and the word goes on up the line. His conduct is soon corrected.

(One authority on O.R. asepsis, Dr. Carl W. Walter of Peter Bent Brigham Hospital, Boston, suggests taking candid camera shots of anyone who wears street

Continued on page 88

How is it that TENSOR Elastic Bandages provide such effective compression at such a low daily cost ?

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A College Education for You?

The experiences of these R.N.s will help you answer this question—and suggest steps to take if your answer is yes

By Patricia D. Horgan, R.N.

You're hearing a lot these days about the advantages of higher education for the nurse. So perhaps you've given some thought to whether or not *you* should enroll for college work.

You may have asked yourself a number of questions, including these:

1. How could I find time to take college work?
2. Would I have to quit my job?
3. Could I meet the expenses?
4. Is college study really worth while?
5. Where, when, and how could I start?

The answers to Questions 1

and 2 are easy: Nearly two-thirds of all professional nurses now taking college work are enrolled for part-time study. They go to classes at times that fit into their work schedules. So they don't have to quit their jobs while taking a portion of their work toward a degree.

The answer to Question 3 is also easy: Most R.N.s pay their bills from their salaries or savings. Others—mainly among the full-time students—receive scholarships from local, state, and national sources. (More about this later.)

Questions 4 and 5 are more subjective. Easy answers aren't possible. But it is possible to report facts and opinions expressed by a noted nurse-educator and six R.N. students. Then you can draw your own conclusions.

The educator is Rozella M. Schlotfeldt, R.N., PH.D., associate dean of the Wayne State University College of Nursing, Detroit. The R.N. students—all studying at Wayne—are Dorothy Coye, an administrative supervisor; Helen Harper, nursing director; Amelia Sasso, former assistant surgical supervisor; Margaret Wolf, ensign in the U.S.P.H.S.; Lenora Webb, former industrial nurse; and Lee Chini, former Navy nurse.

Here's how they answer Question 4: Is college study really worth while?

Dean Schlotfeldt: "Today many R.N.s realize that the nurse needs more than a basic education. They see that most bedside nursing is done by non-professionals. They realize that the R.N. must be able to decide what care she will continue to give and what care she will now only supervise.

Continued on page 78

aureus

patients suggested

infection in hospitals!

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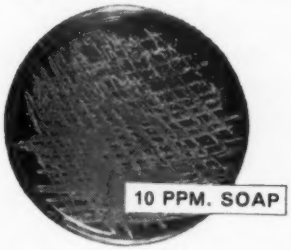
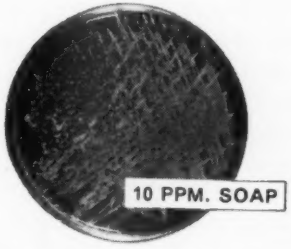
In vitro tests demonstrate Dial's antibacterial superiority against Staph. Aureus



1. Ordinary toilet soap left this heavy Staph growth.



2. A widely used antiseptic soap showed little inhibition of Staph.

3. Dial Soap completely inhibited the growth of Staphylococcus aureus.

"If the R.N. is to fulfill her new role effectively—and feel secure in doing it—she must advance her knowledge through continuing education."

Margaret Wolf: "Education opens the door to promotion. It's the only sure way a nurse can advance herself."

Helen Harper: "Education has more than a dollars-and-cents value. It stimulates you intellectually, gives you a new understanding of yourself and others."

Dorothy Coye: "There's always some way to use your education—to do a better job or to get more enjoyment out of life."

Now for Question 5: Where, when, and how could you start college work? Here's a five-point program suggested by Dean Schlotfeldt:

¶ *Make realistic plans for financing your education.*

You'll probably have to count on making some financial sacrifices. So it's wise to take stock of your resources and earning potential.

Consider starting a special savings account. Many nurses find that by careful budgeting they can put aside enough to

Clinical Study of a New Way of Gargling

THEODORE A. SCHWARTZ, M.D.
WILLIAM H. SLASMAN, M.D.
Mercy Hospital, Baltimore, Maryland

*A new way of gargling is described, which shows definitely greater overall efficacy when compared to the ordinary way of gargling.**

The usual gargle techniques do not permit medications to reach beyond the anterior tonsillar pillars with any predictable consistency. This may be due to a) the triggering of the gag reflex, b) a too brief time of contact and c) an insufficient total amount of medication. Therefore, the evaluation of topical medication for throat complaints is difficult, because of the lack of uniformity in gargling. A new method of gargling was devised in an attempt to overcome these major difficulties.

BACTERIOLOGIC BACKGROUND

It was found in a bacteriologic study using non-pathogenic throats, that the new gargling technique reduces significantly the total bacterial count on the posterior pharyngeal wall, whereas the usual techniques did not. Apparently, this new standardized gargling method brings the solution into contact with the posterior pharyngeal wall for a long enough period and in sufficient quantity to produce marked anti-bacterial activity.

RESULTS

In the present study, only patients with clinically pathologic throats were used. Clinically, the new method was definitely more efficient in providing symptomatic relief than was the standard technique. This was most evident when the pathology was present on the posterior pharyngeal wall. Patients with subjectively bothersome postnasal discharge sometimes experienced quite dramatic relief. The longer the use of the medication with the new technique the more pronounced was the relief.

Interestingly enough, the patients reported that when using the new technique, they could for the first time actually feel the solution in the back of the throat.

CONCLUSION

We are of the opinion that the new way of gargling when performed correctly [1] offers a definite superiority to other techniques.

[1] *Directions of new gargling method: Take about ½ ounce of the antiseptic solution into your mouth. Then, tilt head back slightly. Breathe in deeply through the nose, later breathing out slowly. Thrust tongue forward and, while saying "A-a-h", gargle for 30 seconds.*

cover the cost of full-time study.

Lenora Webb saved her money for eleven years. "Now," she says, "I enjoy college so much that I'm sorry I didn't enroll sooner. I advise other R.N.s to enroll *before* they've saved all the money they think they'll need."

Part-time employment can help you get started earlier. For example, Amelia Sasso first enrolled part time at Wayne, working five days a week to support herself.

Lee Chini saved enough while a part-time student to finance full-time study. Now she helps support herself through occasional private duty.

Scholarships and student grants also offer financial help. Dorothy Coye, for example, received both a local and a national scholarship.

You can get information about scholarships from the institution where you plan to enroll. Or you can write to the National League for Nursing, 10 Columbus Circle, New York 19, N.Y.

Finally, you may want to consider borrowing money, either from the college's loan fund or from a bank. If so, you'll find that nurses usually are considered good financial risks because

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"No cases of sensitization were observed, an indication that the CREAM has a low index of sensitization. There was absolutely no evidence of primary irritancy."

"Based on the findings tabulated, the CREAM seems to be effective in many cases of mild irritation of the skin, in the prevention of infections, when used in time, and in the relief of itching from varied causes."

Summary of studies available to Physicians and Nurses on request.

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their services are always in demand. You can probably get easy repayment terms.

¶ *Set your long-range educational goal before you start.*

Just what is it you want from education? A few courses that will help you do your job better? A bachelor's degree that will broaden your nursing knowledge and put you in line for promotion? Or do you want a master's or a doctorate in a special nursing field?

By answering these questions before enrolling, you can make every course count. That's what Dorothy Coye did.

"I was a head nurse at the time," she says. "Courses in supervision would have filled my need. But I didn't want to be a head nurse forever. I hoped to move up to a higher administrative position. So, instead of taking just a course or two, I enrolled in a full program."

¶ *Select a recognized institution and nursing program.*

To make sure that an institution offers high-quality education and is in good standing, check its accreditation. Two questions are pertinent:

(1) Is the *institution* accredited by a state or a regional accrediting body? (2) Is its *nurs-*

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1. Frech, H. C., and Lanier, L. R., Jr.: Am. J. Obst. & Gynec. 74:1146, 1957. 2. Rosenfield, H. H., et al.: Obst. & Gynec. 11:222, 1958. 3. Hellman, L. D.: To be published.

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ing program N.L.N.-accredited?

Usually, you'll find the answers in the institution's catalog. Or you can write to the N.L.N. for its published list of accredited programs.

By enrolling at an accredited institution, you'll be able to transfer your general education credits to another accredited institution without much, if any, loss. Here's a case in point:

Margaret Wolf began her study at a Detroit college other than Wayne. Then that college discontinued its nursing program. Since both it and Wayne are accredited, Wayne accepted all but one general education course. Also, it allowed most of the credits to be applied toward the Wayne degree.

Knowing that an institution's nursing program is recognized professionally is also important. Some institutions grant a nursing degree that's nearly valueless.

¶ *Get the help of an expert in planning your study program.*

To do this, write or visit the institution in which you hope to enroll. There a nurse-educator whose job it is to keep abreast of educational trends will help you.

This step is especially important if you're planning to study part time only. Otherwise you may be tempted to start with a haphazard selection of courses mainly because they are scheduled at convenient times.

Helen Harper had such an experience. "I'd piled up sixty credits," she says, "before a faculty member took me in hand and insisted that I matriculate (officially enroll for work toward a degree)."

Amelia Sasso says: "Before enrolling at Wayne, I'd accumulated quite a few credits. This made it hard to plan my full-time program. I had no electives left, only field work and other required courses."

¶ *Once you've set up your program, take advantage of every opportunity to move ahead.*

Often, say the Wayne R.N.s, you can get needed liberal arts courses at a near-by accredited college. Or you can enroll for university extension work.

Some universities provide popular extension courses on demand. If you need, say, a certain English course, you can ask the university to offer that course in or near your community. If on registration night a required number sign up, the university will give the course. *More*▶


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A COLLEGE EDUCATION?

To be sure that the required number registers, you can do as school teachers sometimes do: Enlist R.N.s, teachers, and others who will agree to take the course at that time.

* * *

Will a college education be a part of your future? Only *you* can decide, of course.

As these Wayne University R.N.s indicate, college work isn't easy. But they agree that it's a stimulating and worth-while experience. And it *can* help you to move ahead in your career. END

▶ **AMUSING . . .**

▶ **AMAZING . . .**

▶ **EMBARRASSING . . .**

▶ **INTERESTING . . .**

No doubt one of these adjectives describes some incident that has occurred in the course of your work as a nurse.

Why not share the story with other R.N.s?

If it's accepted for publication, you'll receive $15-$25.

Contributions must be previously unpublished. They cannot be either acknowledged or returned. Those not accepted within ninety days may be considered rejected.

Address: Anecdote Editor, *RN*, Oradell, N.J.

Legal Pitfalls in Progressive Patient Care

Continued from page 37

maternal labor. It turned out to be long and dangerously protracted. Her family physician called in an order for I.V. Pitocin. There wasn't an M.D. in the hospital, so the medication was administered by an R.N. without supervision.

Result? The mother had a violent abortive reaction. The baby died during birth and massive hemorrhaging nearly claimed the mother's life.

* * *

The present transition from traditional methods of patient-care to the more streamlined P.P.C. pattern is inevitable and necessary. Inevitable, too, are some of the accidents and close calls that have occurred.

But now we have these accidents before us as examples of what *not* to do. Let's hope that nurses—and those responsible for nurses' assignments—will learn from them how to avoid making similar mistakes in the future. END

How We Insure Peace in Our O.R.

Continued from page 72

clothes in the O.R.—then posting the pictures on the bulletin board!)

The clamp-thrower: When things don't please Dr. D, he's likely to toss instruments. His language can be offensive, too.

Everyone knows that surgeons operate under a severe strain. So they can be permitted some leeway in behavior. But the O.R. nurse doesn't have to tolerate profanity or instrument-throwing. So if Dr. D doesn't calm down, she starts the problem on its way to the chief of surgery.

The individualist: This surgeon scoffs at administrative rules. For instance, he may refuse to write pre-op notes. Again, the nurse initiates action for the sake of her patients *and* the hospital. (These records, in fact, are required by hospital accrediting agencies.)

Of course, nurses don't originate all the complaints we take action on. Nor do we expect

them to. The doctors have some:

¶ The O.R. supervisor who plays favorites. She tries to round up the best personnel and equipment for "her" surgeon. She even tries to rearrange the O.R. schedule to suit him.

¶ The nurse who unfairly questions a surgeon's competence. Her information is based on O.R. scuttlebutt, not on facts.

¶ The nagging supervisor. She finds fault with everything.

¶ The intolerant nurse. She's scornful of all learners in the O.R. She includes residents and internes and other nurses.

Actually, nurses have less excuse than surgeons for creating problems in the O.R. Why? Because one of their main jobs is to see that the O.R. team works smoothly so that the patient will receive the best possible care. They know that dissension in the O.R. has the opposite effect.

At Deaconess Hospital our R.N.s realize they're key members of the O.R. team. Their professional judgment and our hospital's strong organization make an unbeatable combination for insuring peace and maintaining efficiency. END

Chemicals Against Cancer

Continued from page 65

Hodgkin's disease, lymphomas, and leukemia. University of Pennsylvania doctors reported recently that this drug gave so much relief in some cases that they could reduce, or even discontinue, the giving of narcotics.

Cyclophosphamide is considered safer than the earlier cytotoxic drugs. Reports say it isn't irritating and doesn't have to be injected. And it's said to be less likely to cause nausea and vomiting.

Scientists think this may be because it's relatively inactive until it reaches the cancer cells. There, certain enzymes turn it into a form that attacks the malignant tissues. Healthy tissues contain less of these enzymes. Thus, they aren't harmed so readily, and side effects are fewer. Even so, the white blood cell count drops and many patients suffer a temporary loss of all their hair.

Cyclophosphamide doesn't seem particularly effective against solid tumors, such as carcinomas of the lung, stomach, and uterus. But another new drug of this class, triethylene thiophosphoramide (Thio-TEPA), has helped shrink solid tumors in some patients.

Doctors are now using Thio-TEPA in several ways. For one thing, they give it to patients immediately after surgery for cancer of the various internal organs. The idea is to kill off the loose cancer cells dislodged by surgery before they can take root elsewhere. Stopping the growth of tumor-cell seeds in this way may prevent later recurrences of the disease.

They also use it in cases of lung and abdominal cancer to control fluid flow into the body cavities. Some claim it's better for this purpose than radioactive gold.

When given in too-high doses, Thio-TEPA can damage bone marrow just as other chemicals of this class do. So, to help keep it out of the blood stream, it's often injected directly into the tumor.

Surgeons at Tulane University try to isolate the tumor from the general circulation before starting treatment. Here's what they do:

MAKE THIS TEST—Smooth Z.B.T. Baby Powder on your hand. Then sprinkle with water. Note how water rolls off! Z.B.T. moisture-proofs skin, gives baby extra protection.

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YES, because Z.B.T. Baby Powder with Olive Oil actually sheds moisture, it moisture-proofs baby's skin against irritating acid-moisture of wet diapers and perspiration. Soothes like powder, protects like oil. Guards against painful chafing, prickly heat, urine scald and diaper rash. Keeps skin dry and comfortable. Use Z.B.T. Baby Powder after bathing, at every diaper change.

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NOTE: Z.B.T. does not contain zinc stearate or boric acid.

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¶ Using tourniquets, they shut off the blood supply to the cancerous organ.

¶ They connect a vein and an artery from the organ to a heart-lung machine.

¶ As the blood circulates between the machine and the tumor, they inject high concentrations of Thio-TEPA or another alkylating agent.

At first the treatment was limited mainly to the treatment of arms and legs. Recently, however, its use has been extended to include treatment of lung and pelvic cancers.

At Duke University, face and jaw cancers are being perfused in a similar way. There, doctors have found that heating the mixture of blood and drug above body temperature before circulation gives the best result. Now they plan to use this modified method in brain-tumor treatment.

Safer cytotoxic agents have also been made available recently for treating various kinds of leukemia. For example, the new triethylene melamine (TEM) doesn't blister like the parent mustard. Taken by mouth, it's

effective against lymphatic leukemia and widespread Hodgkin's disease.

Even more selective in its action on the blood-forming tissues is chlorambucil (Leukeran). It strikes most specifically at rapidly growing lymphocytes. So it's used to treat chronic lymphocytic leukemia.

For fighting the granulocytic form of chronic leukemia, many hematologists now prefer busulfan (Myleran). Its actions are limited to the bone marrow and, most specifically, to its granulocyte synthesizing elements.

Taken by mouth in small daily doses, it often makes patients feel remarkably better for weeks or months. But overdosage may lead to a drop in thrombocyte (blood platelet) production, thus leading to bleeding. So a close check must be kept on the patient's blood-cell count, including especially the level of thrombocytes. END

The foregoing is part one of a two-part article. Next month Dr. Rodman will discuss the other three classes of anticancer chemicals.—ED.

How Nurses Define Their Own Status

Continued from page 57

other professionals are independent agents and can sell their services on that basis. But the nurse works under the physician. So, even though Dr. Ginzberg thinks she can some day attain professional status, I don't think she ever can." (Mr. Bauerle is so convinced of this that he has left nursing to enter business.)

A majority of R.N.s seem to feel as Dr. Ginzberg does that there are too many nurses for the economy to support at a professional salary level. But Margaret Morgan, Salt Lake City, disagrees. Low salaries, she says, are to a large extent the nurses' own fault.

"We look upon caring for the ill as a work whose major reward is more work," she says. "We forget that Florence Nightingale could ignore the material side of nursing because she was financially independent. Most nurses aren't so fortunate."

Dr. Ginzberg's definition of

the truly professional nurse as a "junior doctor" meets with scant enthusiasm. Says Joyce Bennett of Cupertino, Calif.: "He suggests that we take over some of the doctor's functions just as L.P.N.s, technicians, aides, and practicals have taken over some of ours. This would only add to the confusion."

Another Californian, Mary M. Schicker of Long Beach, says: "This so-called golden opportunity to become junior doctors is meaningless. Our problem is to provide more *nurses,* not more doctors."

Adds Shirley M. Schremp, New York City: "By making this suggestion, Dr. Ginzberg himself misclassifies us. We'll *never* become professionals if we attempt to compete with doctors."

On the other hand, most nurses applaud Dr. Ginzberg's plea that auxiliary personnel be looked upon as useful co-workers, not as competitors. Esther M. Hingaler of Nevada City, Calif., sums up the thinking in these words:

"Nonprofessionals took over the duties that overworked R.N.s didn't have time for. Now some

R.N.s feel angry and frustrated, partly because they've lost former job satisfactions, partly because they feel guilty and doubtful of their own ability. If they'd treated the nonprofessionals as assistants from the first—if they'd guided, taught, and set an example—the situation would be better today."

Terse verse from a disagreeing nurse

With Eli Ginzberg I can't agree;
He's way out on a limb.
His nursing research is, I fear,
Inadequate and dim.

The doctor's education lacks
Some precious bits of learning.
His thesis, based on meager facts,
Has set this nurse a-burning!

—RUTHINA K. GEUBNER, R.N.
WICHITA, KAN.

Many nurses take strong issue with Dr. Ginzberg's suggestion that the diploma-school R.N. be called a technician. "This word belongs in the laboratory or the machine shop," says Edith Yates, San Francisco. "It has too cold a sound for the bedside."

But Dorothy Van Snapson of Bay City, Mich., is less opposed to the idea. "Rather than go back to school at my age," she says, "I would prefer to remain what Dr. Ginzberg calls a technician. Nursing would still seem as noble."

Anna McCullough, San Diego, isn't willing to go quite that far. "Because I don't have a degree," she says, "I've never felt like a first-grade professional. But I *do* think my R.N. entitles me to be called something better than a technician!"

Betty J. Galbreath of Beech Grove, Ind., adds a humorous note: "There are professional ballplayers, politicians, and gamblers (have they been to college?). So why not professional three-year nurses?"

In summary: Dr. Ginzberg's analysis of nursing and its future irked many nurses and pleased many others. But all comments received by *RN* showed one thing in common: The writers considered the author's opinions carefully. Whether they completely agree with him or not, they do share his concern for nursing's problems. END

G.U. Nursing Updated

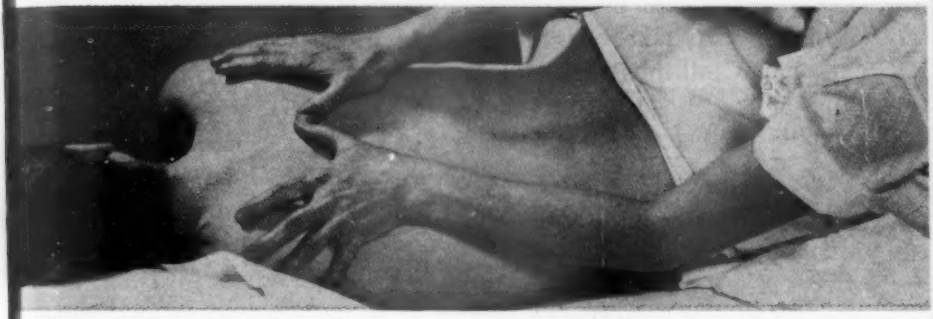
Continued from page 43

eratively. Then he starts the patient on our oral "potion"—a mixture of tea, hot water, sugar, and lemon. This helps prevent distention, and the lemon acts as an effective diuretic."

The first postoperative day the patient is up and walking. This helps his circulation and prevents complications, such as hemostasis.

"This, too, is an advance," Miss Kullman observes. "Patients—especially our older ones—no longer are prisoners of the drainage set-up. Now they can be up and about, socializing with other patients and caring for some of their own needs. They don't have a chance to become withdrawn and dependent. The newer drainage equipment is lightweight. So it's easy for them to carry about or attach to a chair while sitting up."

As long as bladder drainage is necessary, the patient receives a sulfonamide or an antibiotic,



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You will be especially pleased with its smooth consistency, appealing mild fragrance, and its non-greasy, non-sticking properties. Silicare leaves no visible film or coating to impair your manual dexterity.

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—LeVan, P., Sternberg, T.H. & Newcomer, V.D.: Cal. Med. 81:210, 1954.

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as ordered, to prevent urinary tract infection.

The suprapubic tube is removed seven to nine days postoperatively. A retention catheter may be inserted into the urethra at this time to take over urinary drainage and thus allow the suprapubic wound to heal. To protect the catheter from accidental traction, the nurse either tapes the tubing to the patient's thigh or pins it securely to a pajama leg.

She carefully checks the catheter for incrustation in the lumen that might interfere with drainage. She also watches closely for any discharge around the catheter, for temperature elevation, and for perineal pain. Any one of these may indicate a periurethral abscess.

At the end of my visit I thanked Miss Kullman for bringing me up to date on G.U. nursing care. She walked with me to the elevator.

As we passed the patients' lounge, I saw several white-haired gentlemen in bathrobes watching TV and heatedly discussing a basketball shot they'd just seen. Each had a drainage bag on the side of his chair.

"I see what you mean about socializing," I said.

Miss Kullman smiled. "Visit us again during the baseball season," she invited. "Our patients discuss baseball so much that I'm becoming a fan!" END

An order's an order

The student nurse in surgery was visibly nervous.

"Relax," the supervisor whispered. "You know your duties as circulating nurse. If there's an emergency, do exactly as the doctor orders."

Everything went along smoothly. "Cut the suction," the doctor said.

Frantically the young lady reached into her uniform pocket. She flashed a relieved smile at the O.R. team. Then she brought out her bandage scissors and carefully cut the suction tubing in half.

—BETTY KING, R.N.

An Ideal Antacid-Laxative

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WHAT'S NEW IN *Drugs*

Potent Steroid Diuretic: A new synthetic steroid called spironolactone (*Aldactone*) is said to relieve fluid retention that resists usual treatment. So it may help heart, liver, and kidney disease patients with edema.

The new steroid, it's claimed, doesn't deplete the body's potassium stores. Given by mouth (alone or combined with mercurial or thiazide-type diuretics), it counteracts aldosterone, an adrenal hormone that keeps the kidneys from excreting sodium. This helps rid the body of water-trapping salt.

Imported Analgesic: A Belgian pain killer, dextromoramide (*Palfium*), has been introduced in the U.S. after European trials on some 100,000 patients.

The new synthetic is claimed safer and more powerful than morphine. It's supposed to be especially valuable in relieving chronic pain. Suitably spaced oral doses are said to keep dying cancer patients pain-free around the clock.

The drug need not be injected, for it's said to work as well when taken by mouth. Other advantages claimed: It works within five to

fifteen minutes, doesn't cause drowsiness, and doesn't require increased dosage. (But it's a narcotic and does require the usual precautions.)

Two for Sore Throat: Two new products for the relief of throat infections are now available.

The first, bismuth sodium triglycollamate (*Bistrimate*), is claimed best when used for persistent throat irritations. Tablets taken by mouth reportedly relieve chronic cases of tonsilitis and pharyngitis.

The second, *Pharycidin*, is said to soothe milder inflammations when gargled because it contains cetyldimethylbenzylammonium chloride, a penetrating antibacterial base. It can also be swallowed for systemic fever-fighting and pain-relieving effect.

For Stomach Upsets: A new local anesthetic in an alumina gel suspension reportedly relieves stomach pain and discomfort.

The nerve-numbing drug, called oxethazine (*Oxaine*), is said to help control the symptoms of chronic gastritis and other gastrointestinal conditions. It's claimed more potent than procaine and cocaine, described as long-lasting and safe.

Taken orally, it supposedly deadens nerve endings in the stomach wall, thus preventing reflex contractions and secretion.

—MORTON J. RODMAN, PH.D.

letters

Continued from page 16

have been both postoperative and postdelivery complications with hypnoanesthesia. Even severe depressive reactions have been precipitated out by psychiatrically naïve medical hypnotists.

2. According to the article, "as many as 6,000 doctors . . . are said to employ hypnosis occasionally..." This figure is presumably based on the number of enrollees in various of the three-day courses on hypnosis that have been given throughout the country but which—if a malpractice suit involving hypnosis arises—will perhaps not be considered as constituting adequate training for medical purposes (see The A.M.A. News, June 29, 1959).

3. The article mentions hypnosis with the aid of medically trained practitioners. There have been a number of requests by lay hypnotists—who term themselves "hypnotists to the medical profession"—for operating- and delivery-room privileges and for hospital staff appointments. This can be dangerous. Hypnotechnicians are not warranted.

4. Only four institutions are listed in the article as having "rec-

ognized" training programs. To be adequate for medical purposes, training in hypnosis must be taught within a psychodynamic construct. This requires psychiatric teaching and supervision, on a closely supervised basis, within a medical school or teaching hospital, with carefully graded patient-material, over a prolonged period of time—all so planned as to make it possible for the student physician, with this subject as with other subjects, to learn from his mistakes.

Of the institutions you name, one has no psychiatric section and two of the medical schools have discontinued the course because they realized that as organized it was not adequate for medical purposes. Both medical schools are, however, considering plans for more intensive and more adequate courses later on. But much more ambitious and significant teaching of, and research with, hypnotic techniques has been initiated at other institutions. Among them, Tulane, the University of Pennsylvania, Johns Hopkins, and Louisiana State University can be mentioned.

Hypnosis must be treated within a psychiatric context. When patients are hypnotized by nonpsychiatrists, this should be borne in

on the spot coverage

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PD-01

letters

mind. The American Medical Association for this reason has set up its Committee on Hypnosis under the A.M.A. Council on Mental Health. The 1958 A.M.A. Report on Medical Use of Hypnosis, which constitutes the present A.M.A. official policy on the subject, specifically states that mere ability to hypnotize requires little or no technical skill or training, but that a knowledge of psychodynamics (i.e., of basic psychiatry for the nonpsychiatrist) is essential.

Incidentally, the California Medical Association is now considering a resolution restricting all teaching of hypnotic techniques to medical schools and teaching hospitals, and within—not outside—their Departments of Psychiatry. The prevention of adverse sequelae is paramount.

I should like to thank you for emphasizing this. I would feel that by doing this you are rendering an invaluable and significant service, not only specifically to the nurses who subscribe to *RN* but also to physicians throughout the country.

We therefore owe you a debt of gratitude.

Harold Rosen, M.D., Chairman
Committee on Hypnosis
Council on Mental Health
The American Medical Association

RN *thanks Dr. Rosen for his comments, which were received too late for use with the article on hypnosis.*—ED. END

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REGISTERED NURSES: Immediate openings, 30 bed general hospital. Starting salary $350 per mo., 40 hr. wk., sk. time and vacation allowance. Staff will move to new hospital when completed this summer. Apply Supt. of Nurses, Blue Mountain General Hospital, Prairie City, Ore.

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REGISTERED NURSES: Modern 376 bed JCAH fully accredited general hospital. Located on beautiful San Francisco Peninsula, 20 min. drive from the heart of the city. Openings in all services, excellent personnel policies, many extra benefits and opportunities for advancement, top salaries. Apply Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, Calif.

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ortunity for college study, bachelor's degree rogram. Write Head, Department of Nursing ervice, Eugene Talmadge Memorial Hospital, edical College of Georgia, Augusta, Ga.

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VETERANS ADMINISTRATION CENTER: Dayton, Ohio, an 820 bed hospital affiliated with Ohio State University offers opportunities for professional nurses in medical, surgical, geriatric and tuberculosis nursing. Monthly salary: $370 to $795. Facilities for educational advancement at University of Dayton and Miami University. In-service education program ,annual salary increases, 30 days vacation, 15 days sick lv, 8 holidays, retirement plan, living quarters available. Full U.S. Citizenship required. Write: Chief, Nursing Service, Administration Center, Dayton, Ohio.

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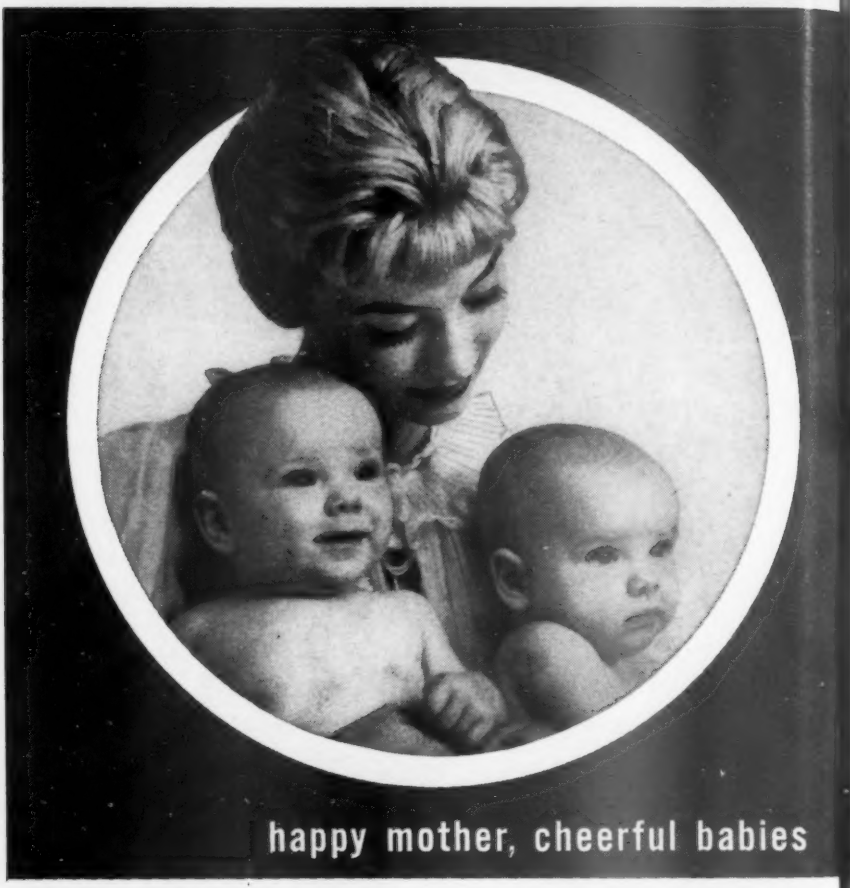

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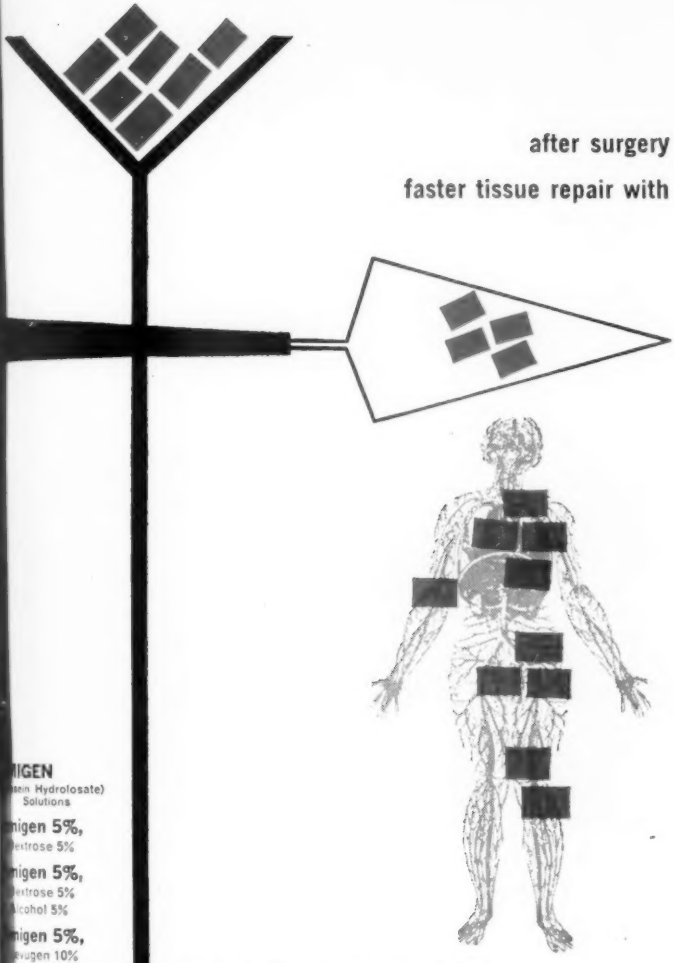

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